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:	No 1 Portsmouth
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	17 July 2023 and 18 July 2023
Centre ID:	OSV-0005679
Fieldwork ID:	MON-0034356

About the designated centre

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

This designated centre provides full-time residential services to a maximum of six adults. Residents living in this centre have been diagnosed as functioning within the range associated with a moderate to severe level of intellectual disability. Residents may have also received an autism or mental health diagnosis. The designated centre comprises three houses located on a campus operated by the provider on the outskirts of Cork City. Two of the houses are adjoining semi-detached houses. Each of these houses is further divided into two living areas. Therefore the four residents living in this part of the centre each have a bedroom, bathroom, living area, and kitchen for their exclusive use. The third house is a two-storey detached building. The centre is staffed at all times, with waking staff working in each unit by night.

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
Monday 17 July 2023	09:50hrs to 18:30hrs	Caitriona Twomey	Lead
Tuesday 18 July 2023	09:30hrs to 15:10hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

This designated centre comprises three houses located on a campus operated by the provider on the outskirts of Cork City. It is registered to provide a full-time residential service to six adults. At the time of this inspection there were five residents living in the centre. Two of the houses are adjoining semi-detached houses. Each house is further divided into two living areas. Two residents live in each house, where they have their own designated living area that includes a bedroom, bathroom, living area, and kitchen for their exclusive use. In each house, staff share an office space and there is one utility room used to store laundry equipment and other items. The third house is a two-storey detached house. It is registered to accommodate two residents, however at the time of this inspection there was one resident living there. This resident had access to the ground floor which contained a bedroom, bathroom, living room, and a separate kitchen and dining room. There were two rooms and a bathroom upstairs. At the time of this inspection, these upstairs rooms were used as offices.

This was an unannounced inspection completed over two days by one inspector. On the first day the inspector visited all three houses, spent some time with five residents, spoke with staff, and reviewed documentation relating to the centre as a whole and one of the houses in the centre. On the second day, the inspector was based in an administrative building and reviewed documents relating to the other two houses in the centre. They also briefly visited one house to review the medication management and fire safety systems in place.

On their arrival at the front door of the first house visited, the inspector was asked by a staff member to enter using another door. It was explained that the presence of a person that the resident didn't know in their living area may be distressing for them. This door brought the inspector into the other side of the house where another resident lived. At the time of the last inspection of this centre completed on behalf of the Chief Inspector of Social Services (the chief inspector), it was found that items belonging to one resident were stored in the area where the other resident lived. Since then the provider had put storage facilities in place to ensure each resident had access to their own belongings in the area where they lived. The inspector saw an item of clothing belonging to one resident drying in the other resident's living area. Management later advised that drying facilities were in place in both sides of this house and until the day of this inspection, spot checks completed by management staff had confirmed that these were being used and that each resident's belongings were stored in their own living area.

As outlined in the opening paragraph, this house was divided into two separate living areas. These were separated by one door that was routinely locked with a key. The use of a key meant that the lock was not part of a fire safety system that would ensure the door automatically unlocked in the event that a fire was detected. There was a window in this door which allowed staff and residents to see into the adjoining area. The office area used by staff was located on one side of this locked

door. Residents' medication, finances, files and other documents were stored here. The utility room was also on this side of the house. Staff were observed regularly going through this door while the inspector was in this part of the centre. The inspector was advised that residents did not use this interconnecting door, and that each used separate external doors when entering and exiting the building.

There were a number of environmental restrictions in place on one side of this house. Due to assessed safety risks, the doors to the walk-in wardrobe and an office area were routinely locked. The kitchen door was also locked regularly. When it was queried why doors were locked with a key rather than fitted with locks connected to the alarm system, management advised that magnetic locks may be damaged due to a behaviour regularly displayed by one resident. The use of keys increased the fire safety risks in this house. It was also noted that the door to the resident's bedroom and kitchen were not fitted with self-closing mechanisms. These mechanisms ensure that doors close fully to provide fire and smoke containment, if required. It was also observed that one bedroom may be an inner room. This means that access to this room was through another room. This arrangement increased the risks to both staff and the resident should evacuation be required in the event of a fire. These risks were somewhat mitigated by the presence of two waking staff in the centre at all times when residents were in the house. However, the provider was required to review the fire safety arrangements in place. Other findings regarding fire safety in other parts of the designated centre are outlined in the 'Quality and safety' section of this report.

The inspector spent the majority of the first day of this inspection in one house, visiting the other two houses later that afternoon. It was a finding of the previous inspection, completed in September 2021, that the cleanliness of the centre required significant improvement. This resulted in the issuing of an urgent action. This required the provider to confirm what actions they had taken, or proposed to take, within a time specified by the chief inspector to address a significant non-compliance with the regulations. On this occasion all three houses were observed to be clean and generally well-maintained. The provider had completed works throughout the centre since 2021 and it was observed to be decorated in a homely manner, in line with residents' assessed needs and preferences. One resident displayed a preference for a minimally decorated environment and the inspector was told that the staff team, with the support of multidisciplinary professionals, were working towards introducing more items into this person's living area, while respecting their preferences. The inspector later saw reference to this in staff meeting minutes. Other residents' living areas reflected their preferences with photographs, artworks, and preferred items on display.

Throughout the centre the inspector saw generally well-maintained comfortable furniture, soft furnishings, televisions, and other activities that residents enjoyed. Residents' bedrooms were personalised and were fitted with equipment to support their assessed needs, as required. There were some areas that required maintenance. These included some damaged chairs and radiators in more than one house, carpet in one house, the fittings in one resident's walk-in wardrobe and in some bathrooms, and painting was required on some walls and ceilings throughout the designated centre. Some of these had already been flagged with the provider's

maintenance department for follow-up.

When in the centre, the inspector observed a number of restrictive practices in use. Not all of these had been notified to the chief inspector, as is required by the regulations. Since this centre was last inspected the provider had submitted an application to vary the centre's registration conditions. This related to the addition of the third house to this designated centre. While in this house the inspector identified that the floor plans submitted with this application were not accurate. A room, described on the floor plans as a relaxation room, was used as a store room for cleaning products and equipment, and other items. Management were asked to submit another application with accurate floor plans.

The inspector saw all five residents in the course of the inspection. The importance of familiar and consistent staff support was highlighted for all five residents living in the centre and for some the presence of new and unfamiliar people could be challenging. Residents' choice to engage, or not, with the inspector was respected. Residents appeared comfortable in their homes and were seen engaging in their usual day-to-day routines. Early in the inspection, the inspector raised concerns with staff and management regarding the clothing one resident was wearing and maintaining their privacy and dignity. Management later confirmed that this had been addressed. Residents also appeared at ease with the staff support provided. Each resident received a minimum of one-to-one staff support during the day. There were waking staff working in each house by night. All five residents were involved in a day service programme with some accessing an integrated service which included supports from residential staff. All interactions with staff, observed and overheard by the inspector, were respectful and unhurried. Staff appeared to have a good knowledge of residents' personalities, preferences, and assessed needs, including the routines that were important to them.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector did review the feedback received from some residents' relatives as part of the annual review process. Relatives of two residents had provided feedback and overall this was positive. One had expressed a wish for a medication reduction plan to commence. The inspector saw evidence during the inspection that this process was underway for some residents living in the centre.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. Staff training was reviewed and was identified as requiring increased oversight. The inspector also looked at a sample of residents' individual files from each house in the centre. These included residents' personal development plans, healthcare and other support plans. Areas for improvement were identified and will be outlined in more detail in the remainder of this report. Fire safety arrangements in the centre also required improvement to meet the requirements of

the regulations.

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

Capacity and capability

Findings of this inspection indicated that the governance arrangements in the centre were not sufficient to ensure that the quality of service provided to each resident living in the centre met the requirements of the regulations. Although there was some evidence of good oversight and leadership, this was not consistent across the centre.

There had been a number of changes to the management arrangements in the centre since it was last inspected on behalf of the chief inspector in September 2021. Since then a new person in charge had been appointed. The former person in charge was on a period of leave prior to leaving their role. This meant that the person participating in management was covering this vacancy for over 11 weeks before taking on the person in charge role in May 2023. They allocated 20% of their working week to this centre. Management advised that a person had been recruited to take on the person in charge role and was due to begin working with the provider in August 2023. A social care leader had also started working in one house in 2023. As will be outlined in this report, findings indicated that the management arrangements in place at the time of this inspection were not sufficient to ensure the service provided was consistent and effectively monitored in all parts of this designated centre.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. Support staff working in one house reported to a social care leader, who reported to the person in charge. Staff working in the other two houses reported to another social care leader who also reported to the person in charge. The frequency of staff meetings varied in the centre. In one house, meetings were happening weekly. The inspector reviewed a sample of these meeting minutes. There was evidence that various multidisciplinary professionals and the person in charge regularly attended these meetings. These minutes reflected a review of recent incidents, and collaboration to develop plans & working systems to address identified issues. Examples included clearly designating staff responsibilities, the development of resident-specific routines, improved communication supports, implementation of safeguarding plans, and referrals to multidisciplinary professionals. The review of these minutes indicated that overall the supports developed and implemented were effective in reducing the number of adverse incidents and in improving residents' participation in, and enjoyment of,

activities. A separate team worked in the other two houses in the centre. These team meetings occurred less regularly, taking place approximately every four to six weeks. A review of these minutes showed that residents and their specific needs were discussed. There was also information shared regarding referrals made and recent multidisciplinary reviews of personal plans. Staff meetings provided all staff working in the centre with opportunities to raise any concerns they may have about the quality and safety of the care and support provided to residents, as is required by the regulations.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in November 2022 and involved consultation with residents and their representatives, as is required by the regulations. This consultation was referenced in the opening section of this report. An unannounced visit had taken place in September 2022 and again in March 2023. It was identified that a number of actions from the plan developed following the September 2022 visit remained outstanding at the time of this inspection. These included ensuring follow-up on recommendations made as part of multidisciplinary reviews of residents' personal plans, that staff training matrices were maintained, and that personal plans and residents' personal development goals were regularly reviewed. No action plan had been developed following the March 2023 visit. It is a requirement of the regulations that a plan is put in place to address any concerns regarding the standard of care and support identified during unannounced visit to the designated centre.

The provider had an additional internal auditing system in place. It was acknowledged that this had not been completed as scheduled. Management advised that as an interim measure, an overview had been completed regarding some areas of the care and support provided in one house. The inspector saw reference to some identified actions when reviewing documents related to this house. Management advised that it was planned to do a similar review of the third house in the centre in the coming weeks. It was acknowledged by management that the needs of the residents and staff team in one house had been prioritised in recent months. While it was clear that this part of the centre had benefited from this increased management support, findings of this inspection indicated that this had a negative impact on the standard of care and support provide in the other two houses. Examples of this are included in the 'Quality and safety' section of this report.

In advance of this inspection, the inspector reviewed notifications that had been submitted regarding this designated centre to the chief inspector. It was noted that there was an inconsistency regarding the reporting of some restrictive practices used in the centre, for example, on some occasions it was reported that one resident's wardrobe was locked, while on others it was not. When in the centre, staff and management confirmed that this restriction was routinely used and should therefore have been notified accordingly. It was also identified that notifications did not outline how often some restrictions were used in the centre. As outlined previously the inspector observed some environmental restrictions in use in the centre, such as a locked cupboard, restricted access to laundry areas, alarms on some doors, and restricted access to the kitchen in the house recently added to the

centre, that had not been notified, as required.

The inspector reviewed the staff training records in one house in the centre. Records were provided for 12 staff, including the social care leader and three staff who worked in the centre on a relief basis. It was identified that a number of staff required training in some of the areas identified as mandatory in the regulations. These included fire safety, training in the management of behaviour that is challenging including de-escalation and intervention techniques, and safeguarding residents and the prevention, detection and response to abuse. There had been a number of safeguarding concerns notified regarding this part of the designated centre. When notifying the chief inspector of one of these incidents in January 2023, the provider had outlined that all staff would complete safeguarding training again. This outstanding training had been identified in the last two six-monthly visit reports completed on behalf of the provider, and was also referenced in a number of staff team meetings. Despite being repeatedly identified, it remained unaddressed at the time of this inspection.

Registration Regulation 8 (1)

The provider had made an application to vary a condition of the registration of this centre in the form determined by the chief inspector. However, it was identified in the course of this inspection that the floor plans submitted to support this application were not accurate.

Judgment: Substantially compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered provider had paid the annual fee outlined in this regulation.

Judgment: Compliant

Regulation 16: Training and staff development

The records reviewed indicated that all staff working in a house where there had been a number of recent safeguarding concerns had not recently completed training in relation to safeguarding residents and the prevention, detection and response to abuse. Training gaps were also identified in the management of behaviour that is challenging including de-escalation and intervention techniques, and fire safety. As referenced in the findings regarding Regulation 28: Fire precautions there were concerns regarding the fire safety arrangements in this house. Staff training gaps in

this area further increased the risk to residents.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had sufficiently staffed the centre, however the governance and management systems in place did not ensure that the supports provided were consistent across the designated centre. The provider had not put in place a robust governance system that reflected the complexity of the service provided. The person in charge's remit meant that only 0.2 of their working week was assigned to this centre. Due to a number of adverse incidents in one house, the person in charge had prioritised this part of the centre and was in the process of identifying and addressing areas requiring improvement in a second house, before moving on to the third. An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed. There was no action plan developed following the most recent unannounced visit, as is required by the regulations. Some of the areas identified as requiring improvement during these visits were consistent with the findings of this inspection. These included improvements required in staff training, the development and review of residents' goals, access to up-to-date behaviour supports and guidance, and a review of fire safety arrangements. It was also identified that there was no review or progress noted on action plans developed following the two most recent medication management audits completed in one house in the centre. At the time of notifying the chief inspector of an adverse incident that occurred in January 2023, it was stated that all staff working in this part of the designated centre would re-attend safeguarding training. At the time of this inspection, five months later, it was identified that some staff had yet to attend this training. The maintenance of documents and records in the centre also required improvement, with duplicate plans in place and conflicting information recorded in different parts of residents' personal plans. Improvement was also required in the recognition of all restrictive practices used in the centre, and in the notifications submitted to the chief inspector regarding their use.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

It was identified that the costs outlined in residents' service agreements with the provider were not consistent with the service provided to them while living in the centre. Management advised that all contracts across the organisation were in the process of being revised due to changes in the provider's policies and the law. Management advised that the costs associated with living in the centre would also

be reviewed as part of this process.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. Some revision was required to ensure that the management staff, organisational structure, and staffing arrangements in the designated centre were accurate. This was addressed during the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all occasions where restrictive procedures were used in the centre were reported to the chief inspector, as is required by this regulation. It was also identified that the reporting of restrictions used was inconsistent and therefore at times inaccurate.

Judgment: Not compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had notified the chief inspector of a period of absence of the person in charge.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The registered provider had given notice in writing to the chief inspector of the procedures and arrangements in place for the management of the designated centre during the absence of the person in charge.

Judgment: Compliant

Quality and safety

Each resident living in this centre was provided with their own living area and, at a minimum, one-to-one staff support during the day. Residents received an individualised service tailored to their needs. While there was evidence of a good standard of care and support provided in some areas, as was referenced in the previous section of this report, the insufficient governance arrangements in the centre resulted in inconsistencies across the three houses in the centre. A number of areas, including positive behaviour support, personal development planning, and fire safety required improvement to meet the requirements of the regulations. These findings will be further outlined in the remainder of this report.

As outlined previously, there had been a focus on improving the service provided in one house. Management spoke with the inspector about work done to review and improve the supports provided to one resident in particular. This was informed in part by an investigation report completed following an adverse incident in 2023. The inspector was told of the importance of predictability for this resident. A number of routines had been developed and documented to facilitate staff in providing consistent supports. Regular staff meetings were also taking place. The return to attending day service five days a week in March 2023 was described as key for this resident. Management spoke with the inspector about the positive impact of this. The resident was supported to attend by a member of the day service staff team and also by a staff working in this designated centre. A daily walk had also been introduced and was reported to be going well. The inspector was told that prior to January 2023 this person would rarely leave the bus when out in the community.

Across the centre there was evidence of residents being supported to engage in activities in their homes, on the campus, and in the wider community. One resident had recently started attending a day service located on the campus. They were gradually spending more time there and this approach was reported to be going well. They also enjoyed meeting with friends in the canteen located on the campus, and spending time in the local community where they liked going to the cinema and the shops. Some residents had enjoyed holidays away from the centre, with one going on an overnight visit to Galway to celebrate a significant birthday. A referral had been made for input from an occupational therapist to enhance the sensory room in one house. There was evidence that residents were supported to be involved in everyday activities in their homes such as planting and watering in the garden areas.

The inspector read a sample of residents' assessments and personal plans. At least one was reviewed from each house in the centre. Personal plans include guidance on the support to be provided to residents. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care,

healthcare and other person-specific needs. It was identified that in some cases where a healthcare need had been identified, a corresponding healthcare plan was not in place. The maintenance of personal plans was not consistent across the centre. While some had been recently reviewed and updated, parts of others had not been reviewed in the last 12 months, as is required by the regulations. There were often duplicates of information, for example a hay fever healthcare management plan and a separate hay fever protocol. At times it was difficult to identify which was the most recent document as they were not always dated. Although some documents were signed to indicate that they had been reviewed, it was clear that the information had not been reviewed and the effectiveness of the plans was not assessed, as is required. For example, one support plan outlined that consideration was being given to the use of a harness while a resident was travelling in a car or bus. Despite being reviewed twice since then it was not clear if this had been trialled or was still under consideration. Another referenced that an activity was to be trialled. Despite three noted reviews it was not clear if this trial had taken place and what the outcome, if any, was.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. These goals were personal to the residents and reflected their interests. As with other aspects of the care and support provided, the development and review of personal development goals was not consistent across the centre. One resident did not have a current personal development plan. For one resident regular reviews were taking place which documented any barriers to success, and progress made. For others there were inconsistent reviews. This was not in keeping with the provider's own processes and procedures. As a result it was not possible to determine what, if any, progress had been made in achieving some goals.

A multidisciplinary review of each plan had been completed in the last 12 months, as required. It was evident that residents' participation in these reviews had been considered. It is a requirement of the regulations that any recommendations arising out of a multidisciplinary review, including those responsible for following up on those recommendations, are recorded. Although recommendations were documented, it was not possible to determine if these had been followed up or who had been assigned this responsibility. Management advised that the provider was looking at addressing this shortcoming across the service as a whole.

The review of behaviour support plans was not consistent across the centre. For one resident there was evidence of a recent review of their plan. This review had involved input from the staff team, management, and a number of multidisciplinary professionals. However, although there were documented proactive strategies in place, the guidance for staff to follow should this resident engage in behaviours that posed a safety risk to themselves or others was dated July 2020. The inspector was informed that a meeting was scheduled later that week to review this document. Similarly when reviewing some documented routines for this resident, the inspector noted that although they included the possibility of specific behaviours occurring, there was no guidance for staff as to how to respond to, and support, the resident

at these times.

When reviewing a behaviour support plan in place for another resident, it was identified that this was written in 2019, and last reviewed in 2021. Since then there had been changes in circumstances for this resident, including their living arrangements. This resident still required support in this area, as evidenced by a statement in the minutes of their most recent multidisciplinary review that their behaviour posed a challenge to progress with meaningful goals. There was reference to a withdrawal protocol in another resident's personal plan, however another document stated that this had been discontinued in January 2023. There was no guidance available on the day of inspection which outlined how staff were to respond should this resident engage in behaviours that had a negative impact on them or others. Clear, up-to-date guidance was required for staff outlining how to respond to behaviour that is challenging and to support residents to manage their behaviour.

Various documents in one resident's personal plan referenced a number of restrictive practices. These included restricted access to the utility room and kitchen at times, the use of external door locks and door alarms, and devices to secure the position of the seat belt and buckle when travelling. An undated document stated that the use of door alarms was not required during the day due to the staffing supports in place, however these were heard throughout the first day of this inspection. As outlined previously in this report there were a number of restrictive practices used in the centre. As they were not all recognised, they had not been subjected to the provider's policies and procedures.

There had been a number of safeguarding concerns and incidents notified to the chief inspector regarding residents living in this centre. Half of these related to one resident. The inspector reviewed the safeguarding plan in place for this resident. There was evidence that this was being implemented as outlined. Staff spoken with were familiar with the safeguards in place. Management had gone through a presentation on safeguarding at a recent team meeting and the provider's designated officer was scheduled to attend a staff meeting in August 2023. However, it was identified that not all of the staff working with this resident had completed training in relation to safeguarding residents and the prevention, detection and response to abuse, as is required by the regulations.

Following the notification of safeguarding incidents involving another resident of the centre, the provider had informed the chief inspector of a plan to liaise more regularly with the staff team supporting this resident while they attended their day service. This was a line of enquiry for this inspection. Staff spoken with outlined overall improvement in the communication between the two services and referenced a verbal handover between the staff teams each day and the use of a communication book. Management advised that a social care leader and the day service manager now had regular meetings using video conference technology.

The inspector also reviewed medication management practices in the centre. There were additional safety precautions in place in two houses regarding the storage and administration of medicines. These included the use of closed-circuit television

(CCTV) cameras and additional stocktakes. These were introduced following a number of incidents where residents' medicines could not be accounted for. These incidents had been a line of enquiry of previous inspections of this designated centre. There had been no incidents of this nature since the centre was last inspected in September 2021. Medication management audits had been completed in all three houses in 2023. Each audit had identified a number of actions to be completed. In two houses all identified actions were documented as completed. However in the third house it was not documented that any actions had been taken as a result of the two most recent audits, with some repeated findings noted. Following an adverse incident, the provider had informed the chief inspector that a medication administration protocol would be developed for one resident. Although management and staff were confident that this had been completed, it was not available for review when requested by the inspector.

The inspector reviewed the systems and processes in place in one of the houses with additional safety precautions. Medicines were stored in a secure, dedicated area of the staff office. There were designated storage spaces for each resident's medicines. There was a separate area for medicines to be returned to the pharmacy for disposal, as required. When reviewing one resident's prescription it was noted that the administration times for one medicine had been changed. These changes were not signed or initialled by the prescriber, in keeping with the provider's own policy. Management committed to addressing this. The inspector saw one cream labelled with a resident’s name, and to be used on a PRN (as the needs arises) basis. This was not included in the resident's current prescription. It was also identified that not all prescribed PRN medicines were in stock. Staff explained that these were not currently available in the pharmacy due to national shortages. From the sample reviewed medicines were clearly labelled, administration records were completed in full, and the number of medicines present was consistent with the most recent stocktakes. When reviewing the medicines in stock, staff noted that the foil packaging was damaged on one tablet. They expressed their intention to administer the tablet that day. This was not consistent with the administration guidance for this medicine. Management present ensured that this medicine was separated to be returned to the pharmacy.

Fire safety was also reviewed. As outlined in the opening section of this report it was found that the fire safety arrangements in one house required review. The inspector also reviewed the fire safety arrangements in the adjoining house. While there it was seen that the location of the dustpan and brush prevented the door to the kitchen from closing. This was addressed immediately. It was also observed that the door to the relaxation room was not fitted with a self-closing mechanism. When reviewing the fire safety documentation it was noted that the escape routes were not clearly outlined. As described earlier, this house was subdivided to provide each resident with their own designated living area. To facilitate this separation some doors in the house were locked. Due to this layout, depending on where they were in the building, not all fire exits were accessible to residents and staff. Clarity regarding escape routes was therefore especially important. Both residents living in this centre had a personal emergency evacuation plan (PEEP). It was identified that there were multiple versions of these documents, some dated within one month of each other available. For one resident it was identified that they required the

support of two staff to safely evacuate. As there may not be two staff available to support this resident at all times, the provider had an arrangement in place whereby staff were to contact other houses based on the same campus for staff support to aid evacuations. This was not referenced in the fire evacuation procedures seen by the inspector. The inspector reviewed the fire drill evacuation records available. These did not indicate the location of the fire or the evacuation route taken. It was indicated that five evacuation drills had been completed in this house in the previous 12 months. One of these drills, completed in January 2023, was in night-time conditions. The record of this drill was not available. When reviewing the other drill records it was noted that on one occasion it had taken eight minutes to evacuate both residents. This was in excess of the time identified as safe by the provider. Despite this, it was noted on the record that this was a successful evacuation. These findings indicated that the fire safety arrangements in all parts of the centre also required review.

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes. Due to the layout of the centre, each resident had their own private living area to spend time with visitors.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests, and wishes. One resident had resumed attending a day service this year and another had recently started attending a few hours a day to see if they would like it. Referrals had been made to multidisciplinary professionals for their input in improving recreational spaces available in the centre, and to identify and support participation in new activities. Residents spent some time in their local community and there was evidence of ongoing efforts to increase access to activities outside the campus setting.

Judgment: Compliant

Regulation 17: Premises

All houses in the centre were observed to be clean and well-decorated. Residents' bedrooms were personalised and sufficient storage for their personal belongings was

available. Although the premises were generally well-maintained, some items, including radiators and chairs, required repair or replacement. Painting was also required in areas. Due to the layout of two houses in the centre, two residents did not have access to laundry facilities. This unreported restriction is referenced in the findings regarding Regulation 7.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was evidence that residents were offered a choice of wholesome food while living in the centre. Many residents had received the supports of a dietitian and there was evidence that these recommendations were being implemented. It was planned for some residents to become involved in aspects of food preparation, and some already enjoyed baking. There were recently reviewed plans in place for residents who required additional supports at mealtimes. Staff were familiar with these plans. When in one kitchen in was noted that the refrigerator temperature had not been within the range assessed as safe by the provider for the previous three months. Although the temperature had been recorded daily, no corrective action was taken. Therefore there were inadequate arrangements in place to store food safely.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The fire safety arrangements in the centre required review. One bedroom in the centre appeared to be an inner room. Some fire doors throughout the centre, including one to a kitchen, were not fitted with self-closing mechanisms. Evacuation routes were not clearly outlined. This was of particular concern given the layout of two houses in the centre and the locked doors in place. The documented fire evacuation procedure in one house did not include calling for support from other houses, as was required to evacuate this house safely at night. Evacuation drills did not identify the location of the fire or the escape route used. The record relating to an evacuation drill completed in night-time conditions in January 2023 was not available. In another drill record the time taken to evacuate the house was in excess of the time assessed as safe by the provider. This had not been recognised or escalated as a risk.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had practices in place relating to the ordering, prescribing, storage, disposal and administration of medicines in the centre. Some improvement was required to ensure that these practices were implemented consistently in the centre. Areas requiring improvement included staff awareness of when to dispose of medicines, ensuring all medicinal products were included on residents' prescriptions and ensuring that any changes made to prescriptions were signed by the prescriber. It was noted that medication fridges could not be locked and their temperatures were not consistently recorded. These were not used to store medicines on the day of this inspection. Due to previous incidents, additional safety precautions were in place in two houses in the centre. These included the use of closed-circuit television to monitor the handling of medicines and more frequent stocktakes of medicines. These precautions were reviewed and were found to be implemented effectively in the centre. There had been no concerns regarding unaccounted for medicines since the last inspection of this centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

An assessment of health, personal, and social care needs had been completed for each resident in the previous 12 months, as is required by the regulations. A comprehensive personal plan was in place to provide guidance to staff in supporting residents' assessed needs. The inspector's review of a selection of personal plans indicated that there was often more than one version of support plans included, and information throughout the personal plan was not always consistent or up-to-date. The development and review of residents' personal development plans required significant improvement. Not all residents had a current personal development plan and for those that did, not all goals had been reviewed in line with the provider's procedures. Some goals did not relate to personal development and instead referenced the implementation of healthcare support plans. It was noted for one resident that not all assessed healthcare needs had a corresponding support plan. An annual review, involving multidisciplinary professionals, of each resident's personal plan had taken place. Although recommendations made had been documented, it was not possible to determine if these had been progressed or implemented.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had an annual healthcare assessment. There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required. There was also evidence of input from dentists and other health and social care professionals such as speech and language therapists, psychologists, and dietitians. Areas identified as requiring improvement in residents' healthcare support plans are reflected in the findings in Regulation 5.

Judgment: Compliant

Regulation 7: Positive behavioural support

Work had been completed in recent months to develop and implement proactive approaches to reduce the likelihood of one resident engaging in behaviours that impacted negatively on themselves and others. This had contributed to a notable reduction in the frequency of these incidents. However there was no guidance available for staff to follow for when such incidents did occur. There was a meeting scheduled with a member of the management team and multidisciplinary professionals to develop this plan. Not all residents who required one had a recently reviewed behaviour support plan in place. It was documented that one resident's long standing behaviour affected their daily opportunities. Despite this, their behaviour support plan was last reviewed in 2021. For another resident, there was no guidance available on how to respond should they engage in certain behaviours. This resident's personal plan contained contradictory information regarding the use of a withdrawal protocol. Therefore staff did not have up to date knowledge to respond to behaviour that is challenging and to support residents to manage their behaviour, as is required by the regulations.

There were a number of restrictive procedures used in the centre. Not all of these had been identified and therefore subjected to the provider's restrictive practices policies and procedures. These included no access to laundry areas for a number of residents, the use of a half door to restrict access to the kitchen, a locked cupboard containing activities, and the use of alarms on internal and external doors. The use of some door alarms on the day of the inspection was not in line with documents regarding their use in the resident's personal plan. Clarity was also required regarding the use of harnesses, angel guards and other devices used while residents were travelling and if these were considered by the provider to be restrictive or not. Management advised that a review of these policies and procedures was underway and was expected to be completed in the coming months.

The finding regarding staff training is reflected in Regulation 16.

Judgment: Not compliant

Regulation 8: Protection

All safeguarding concerns had been addressed in line with the provider's and national safeguarding policies. There was evidence of regular contact with the provider's designated officer who was scheduled to attend a staff meeting in one house in the month the following this inspection. There was evidence of liaison with the local safeguarding and protection team, as appropriate, and regular review of safeguarding plans. Actions, as outlined in safeguarding plans, were in place on the day of inspection. The finding regarding staff training in relation to safeguarding residents and the prevention, detection and response to abuse is reflected in Regulation 16.

Judgment: Compliant

Regulation 9: Residents' rights

Residents living in the centre received an individualised service adapted to their individual needs and preferences. As the residents living in this centre did not typically spend time with their peers while in the designated centre, in place of residents' meetings staff had initiated one-to-one meetings with residents to provide updates and consult with them regarding their supports and any upcoming events. Staff used visual information to support residents' understanding in these meetings. As was found on previous inspections, clothing belonging to one resident was seen in another resident's living area. This was addressed during the inspection and the inspector saw that drying and storage facilities had been provided in both sides of this house since the last inspection. It was identified early in the inspection that the clothing provided to, and worn by, one resident did not maintain their privacy and dignity. Management advised that better fitting clothing had recently been purchased and ill-fitting clothes were disposed of before the end of this inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 8 (1)	Substantially compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for No 1 Portsmouth OSV-0005679

Inspection ID: MON-0034356

Date of inspection: 17/07/2023 and 18/07/2023

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**
Registration Regulation 8 (1)	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 8 (1): The Provider will ensure that: • Updated floor plans and SOP are to be submitted with an application to vary. 31/10/2023	
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 ensured that: • Staff requiring 'prevention, detection & response to abuse' training will be completed by 23/10/23. • The designated officer delivered safeguarding team training specific to the centre on the 23/08/23 & the 12/09/2023 as part of continued professional development of the team. • Staff requiring Fire Safety training will be completed by the 30/10/23. • Staff requiring training in the management of behaviour that is challenging, have watched a demonstration video of low arousal/de-escalation approaches to behaviours that challenge, while awaiting for the in person training. Application for this training has to be submitted to training department and is due to be completed by 31/10/2023.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider has ensured that:
• There is a clearly defined management structure in place as detailed in the Statement of Purpose.
• A new area manager/PIC has now being appointed and has greater protected time for this designated centre, this person provide greater oversight to ensure implementation of all actions and consistency across all houses in the centre.
• Outstanding Training needs identified or required will be completed by the 31/10/23.
• The incoming PIC will complete an audit of documentation to ensure the most relevant and update information is contained in the residents files 30/11/23.
• All outstanding actions from recent medication audits have been completed. 31/8/2023
• Resident's goals have all been reviewed within agreed timeframes & will continue to be reviewed on a 6 monthly basis.
• A restrictive practice log book is in place to support the recognition of all restrictive practices in the centre. This was completed in August 2023.
• The 6 monthly unannounced provider visit, will be inclusive of an action plan with clear timelines for completion.
• An initial fire safety review was conducted to ensure no immediate risks presented 19/7/2023
• A review of current fire safety measurements are underway with implementation of any identified actions by 31/10/2023.

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

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The Provider has ensured that :

• Resident's service agreements have been updated and added to the resident's files as of the 27/09/23.
• The residential charges will be reviewed. 14/11/2023.

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 shall ensure
• That all quarterly notifications are provided to the inspector at the end of each quarter and will include the frequency of use of Restrictive practice. Next return 31/10/2023.
• A restrictive practice log was developed to support the accurate identification of restrictions within the centre. 10/08/2023
• All returns moving forward to the inspector will be divided into each individual house to provide clarity to the inspector in identifying restrictions.
• The person in charge completes a restrictive practice self-assessment every 6 months in the designated centre. Any unplanned use of a restriction would be notified to the inspector.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider has ensured:
• That there is a continual process of maintenance in the designated centre.
• Furniture items identified at the inspection have been replaced or are in the process of being replaced 30/11/2023
• The sinks and taps have been upgraded in one kitchen to improve access for a resident. 21/09/23
• A request has been made to maintenance about painting several areas – this will be completed by the 30/10/23.
• A restrictive practice log book is in place to support the recognition of all restrictive practices, including access to laundry, in the centre. 31/10/2023

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The person in charge has ensured:
• That residents are as actively involved in the ordering, purchasing and preparing of meals as is reasonable and practical. And continue to ensure that all staff are familiar with any meal plans in place as advised by the MDT.
• New thermometers for both fridges in one house were purchased in August 2023 and these are being checked on a daily basis.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider has ensured:
• An initial fire safety review was conducted to ensure no immediate risks presented and recommend fire safety enhancements, this will be included on the application to vary. 19/7/2023
• That effective fire safety management systems are in place, including identifying escape routes and a log of who to call for support in the event of an emergency. 24/7/2023
• New fire doors have been ordered and will be fitted the week beginning the 9th of October with the works to be completed by the 13th of October. These will include thumb turns on one side of the door in an adjoining apartment.
• The night time evacuation protocol was updated and filed on the 29/09/23.
• An increase in fire drills are now in place for a period of 3 months to support safe evacuation times, a record of the fire drill will be maintained including the location of fire.
• A review of current fire safety measurements are underway with implementation of any identified actions by 31/10/2023.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Person In Charge has ensured that:

• The policy for the safe disposal of medication will be discussed at the staff meetings in all houses in the coming weeks – 04/10/23 & 11/10/23 and for the following 3 staff meetings to ensure all staff are aware of the procedure.
• Medications are held securely stored in a locked cabinet or fridge as appropriate in the Centre 06/10/23
• Regular temperature checks are conducted on recorded for the medication fridge. 6/10/2023
• The Kardex is signed by the prescriber.
• Staff are continually receiving medication training and attending their refresher courses.
• Medication audits continue as per audit schedule and all actions are implemented in identified timeframes.

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:
The person in charge has ensured that:
• The incoming PIC will complete an audit of documentation to ensure the most relevant and update information is contained in the residents files, and ensure duplicate information is removed. 30/11/23.
• Personal plans are reviewed on a regular basis as per policy & that only one plan is in place in a current folder at any one time. All actions are assigned to an identified staff member.
• Personal development plans are reviewed as per policy which has recently changed from 3 months to 6 months.
• Identified healthcare needs have a support plan in place as per assessed needs.
• All actions to progress or implementation of recommendations, including from the MDT following an annual review are documented in a clear manner. Actions will be completed by 18/12/23.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The person in charge has ensured that :
• Staff requiring training in the management of behaviour that is challenging, have watched a demonstration video of low arousal/de-escalation approaches to behaviours that challenge, while awaiting for the in person MAPA training. Application for this training has to be submitted to training department and is due to be completed by 31/12/2023
• A protocol regarding response to behaviour that challenges for one person is being supported by psychology. Their support plan was completed on the 18/09/2023.
The Provider has ensured that:
• A restrictive practice log was developed to support staff in the identification restrictions in August 23.
• The person in charge is engaging with the behaviour standards committee to ensure all restrictions are known to the committee and sanctioned. The block referral system is being used. Reactive strategies are in place persons who require them.

• The provider procedure will set out the system of ensuring behaviour support plans are reviewed on a consistent basis. 30/11/23

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Provider has ensured that:
• A discussion with staff following the inspection ensuring reinforcement of residents rights.
• Each resident's privacy & dignity is respected in relation to his or hers personal living spaces by reminding staff about laundry and by the use of spot checks on a regular basis. This will also be discussed at the next two team meetings – 04.10.23 & the 11.10.23. Dignity & Respect as a general topic will also be discussed at these meetings.
• The residents will be continue to be actively encouraged to engage & participate in decisions about care & support with the necessary support from staff, this will be reviewed at the regular resident meetings.

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
Registration Regulation 8(1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Substantially Compliant	Yellow	31/10/2023
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	30/10/2023
Regulation 17(1)(b)	The registered provider shall ensure the	Substantially Compliant	Yellow	30/11/2023

	premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 18(1)(b)	The person in charge shall, so far as reasonable and practicable, ensure that there is adequate provision for residents to store food in hygienic conditions.	Substantially Compliant	Yellow	31/08/2023
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.	Not Compliant	Orange	30/11/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and	Not Compliant	Orange	30/10/2023

	quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	27/09/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/10/2023
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/10/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	29/09/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the	Substantially Compliant	Yellow	30/10/2023

	event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	24/07/2023
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	11/10/2023
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	Not Compliant	Orange	31/10/2023

	the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/11/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	18/12/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more	Substantially Compliant	Yellow	18/12/2023

	frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	18/12/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/12/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and	Not Compliant	Orange	30/11/2023

	evidence based practice.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	18/09/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	11/10/2023