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:	Blossom Hill
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	31 July 2023 and 01 August 2023
Centre ID:	OSV-0007921
Fieldwork ID:	MON-0031505

About the designated centre

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

Blossom Hill consists of a single unit detached bungalow located near Kilkenny City and close to all local amenities. This designated centre offers a full time residential service, open all year with no closure. Blossom Hill provides a home from home environment for up to four adults with a severe/profound intellectual disability and who may also have a co-existing physical disability, mental health diagnosis or exhibit behaviours that challenge. People supported availing of services in this home present with many related diagnoses ie. visual and hearing impairments, epilepsy, and autism.
Four people currently reside in this home and this centre can cater for adults over eighteen years of age, male and female. This is a high support home staffed by a person in charge, a team leader, nursing staff and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 31 July 2023	12:00hrs to 17:40hrs	Miranda Tully	Lead
Tuesday 1 August 2023	09:20hrs to 15:30hrs	Miranda Tully	Lead

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision regarding the renewal of registration for this designated centre. The inspection took place over two days. Two other inspections were also carried out over that time frame in other centres operated by the registered provider. Some overarching findings in relation to the provider's oversight and governance and management arrangements were identified in all three centres inspected, in addition to improvements required in financial safeguarding, the management of resident possessions and submission of notifications to the Office of the Chief Inspector. This report will outline the findings against this centre.

The inspector used observation, discussion with staff and reviewed documentation to determine residents' experience of care and support in the centre. Residents communicated in a variety of ways including through vocalisations, use of pictures and tactile interaction with familiar staff. The residents living in this centre were unable to tell the inspector in detail their views on the quality and safety of the service. However, the inspector saw that residents appeared content and relaxed in the centre and were comfortable in the presence of the staff supporting them.

Over the course of the inspection the inspector met all four residents who lived in this centre. On the first day, the inspector met with a resident who was watching a film at the time. A second resident was in their bedroom, sitting on their bed which was a recent new purchase for them. A third resident was observed enjoying free movement, in a self contained activity room to the rear of the house in the garden. The person in charge informed the inspector that the fourth resident was at a scheduled swimming session. The inspector later met this resident on their return to the centre.

On the second day of the inspection the inspector arrived as residents were eating breakfast supported by staff and preparing for the day ahead. Three residents left the centre supported by staff in accessible vehicles provided by the centre, while one resident remained in the centre. This resident engaged in free movement as part of their sensory programme in the activity room supported by one staff member. Residents appeared comfortable and content in the presence of staff.

The inspector carried out a walk-through of the designated centre accompanied by the person in charge. The centre was a single-storey house which comprised of a kitchen/dining room, adjacent sitting room, office, utility, four individual bedrooms, one of which was en-suite, and a shared bathroom. The premises also included a self-contained activity room accessible through the garden. The premises had been recently painted and was decorated in a homely manner. The premises was observed to be visibly clean and well-maintained.

In summary, it was evident that the residents received a good quality of care and support. However, there were some areas for improvement which included

governance and management, staffing, notification of incidents, personal possessions, and health care. Overall, the residents appeared content in their home and in the presence of staff members throughout the inspection.

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

Capacity and capability

There was a clear management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge reported directly to the Assistant Director of Services and Director of Services.

On the days of inspection, there were appropriate staffing levels in place to meet the assessed needs of the residents. From a review of the roster, there was an established staff team in place. However, improvement was required as the centre was operating with a number of staff vacancies and there was a reliance on the use of agency staff to meet the staffing complement and fill the centres rosters. The provider was working very hard to try and fill these staff vacancies but highlighted difficulties in filling staff posts.

Overall, the findings of the inspection were that the provider and the local management team were for the most part identifying areas for improvement and taking action to bring about the required improvements. However, governance and management in this centre, required more consistency and continuity in terms of supervision, oversight and monitoring of both the staff team and the care and support of the residents. For example, where audits were completed and had identified areas for improvement, actions had not been completed effectively.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted all of the required information with the application to renew the registration of the designated centre. The provider was requested to amend and resubmit floor plans and the statement of purpose. These were submitted following the inspection.

Judgment: Compliant

Regulation 15: Staffing

The inspector reviewed the roster and this was seen to be reflective of the staff on duty on the day of inspection. At the time of inspection, there were a number of staff vacancies for example, two nurse vacancies and one social care worker vacancy in the centre. This was found to impact on the continuity of care and support to residents. The inspector was informed that the provider was actively recruiting to fill these vacancies.

While agency staff were in use, the reliance on agency staff had reduced significantly since the last inspection. In addition, regular agency staff were utilised as much as possible.

A sample of staff files were reviewed and found to contain the information required by the regulations.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training was provided to staff in a range of areas such as fire safety, safeguarding, infection prevention control and medication management. The inspector reviewed the staff training records and found that for the most part, all staff had received up-to-date training or refresher training had been scheduled with the exception of managing behaviour that challenges.

The staff team in this centre were supported in their role by the completion of formal supervision and a clear staff supervision system was in place. The inspector reviewed the schedule for supervision meetings and a sample of the supervision records. A number of records were not filled on the day of inspection. A schedule for supervision was in place to ensure staff were adequately supervised for the remainder of the year.

Judgment: Substantially compliant

Regulation 22: Insurance

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were management systems in place in the centre, however the effectiveness of such systems required review. The registered provider had appointed a full-time, suitably qualified and experienced person in charge. The person in charge reported directly to the Assistant Director of Services and Director of Services.

The provider and the local management team were for the most part identifying areas for improvement and taking action to bring about the required improvements. However, governance and management in this centre, required more consistency and continuity in terms of supervision, oversight and monitoring of both the staff team and the care and support of the residents. For example, the provider had not followed internal guidance in relation to the completion of investigations following allegations of abuse.

The provider had completed six-monthly reviews and an annual review of care and support in the centre. The annual review 2022, however had limited feedback from residents and their representatives. While audits were identifying some areas of improvement, clear progression and completion of actions was not evident on the day of inspection. In addition, actions from previous inspections were not complete.

Judgment: Not compliant

Regulation 3: Statement of purpose

Following a review of the statement of purpose prior to the inspection it was found that this document did not accurately contain all the required information as set out by the regulations. This was subsequently reviewed and re-submitted, however, it still failed to meet the requirements.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had not implemented effective information governance arrangements to ensure that the designated centre complied with notification requirements. The person in charge had not ensured that incidents were notified to the Chief Inspector within the specified timeframe.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the provider and local management team were striving to ensure residents were in receipt of a good quality and safe service. The inspector reviewed a number of areas to determine the quality and safety of care provided, including review of risk management, health care, personal possessions, protection, fire safety and infection control systems. The provider was for the most part identifying and responding to areas that required improvement.

The management of residents' finances required significant review from an organisational stand point. Due to the current systems in place, at times residents had limited access to their finances. In addition, the systems in place to ensure residents finances were safeguarded were inadequate. Although, these areas of improvement were known to the provider, effective actions to address these issues were still required.

Improvement was also required in healthcare plans to ensure the staff team were appropriately guided on the current supports in place for residents health care needs. For example, inconsistencies were found in relation to residents' epilepsy assessment information and respiratory care. Evidence of ongoing health checks were not evident to ensure residents optimal health.

Regulation 12: Personal possessions

All residents in this centre had Health Service Executive (HSE) Private Patient Property Accounts (PPPA) with clear pathways in place to guide in the use of these. Access to finances have to be requested through the main central office. As staff here were only available during office hours, access to resident monies after these hours was limited. These restrictions had previously been identified in other centres operated by the provider. The provider has acknowledged that this practice requires review and there is a plan in place, however, on the day of inspection the practice remains in place.

In addition, a comprehensive inventory of residents' possessions was not available to review. While a monthly log of purchases and gifts was maintained, records were not consistently maintained and did not include significant purchases such as furniture.

Judgment: Not compliant

Regulation 17: Premises

The premises was purpose built to suit the assessed and future needs of the residents that lived there. The centre was seen to be clean and adequately maintained and was decorated in a manner that suited the residents' preferences. Efforts had been made to personalise the decor in the centre for the residents that lived there and there was a homely environment present in the centre. Residents had access to a large, pleasant garden area that contained suitable furniture for the enjoyment of residents, if desired. Consideration had been given to the residents preferences in planning for the future development of this area.

Judgment: Compliant

Regulation 20: Information for residents

The provider had devised a guide for residents that contained all the required information as set out by the Regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents, staff and visitors were protected by the policies, procedures and practices relating to risk management in the centre. The provider's risk management policy contained all information as required by the Regulation.

A centre-specific risk register was in place which identified a number of specific risks and had been reviewed on a regular basis. There was also individualised risk assessments in place which were also updated regularly to ensure risks were identified and assessed.

The provider had now moved to recording incidents on the National Information Management System system. Incidents were being reviewed by senior management and members of the multi-disciplinary team as required. This was resulting in more informed risk management processes.

Further consideration was required in relation to practices when staff are lone working in the activity room located at the end of the garden . Staff were required to carry personal mobile phones to seek additional support in the event they required support for manual handling or in the event of an emergency. There was no evidence this was communicated with staff.

In addition, the provider had not responded to the risk associated with the inappropriate storage of a sharps bin. For example, sharps bins continued to be stored inappropriately on top of units, this posed a risk of needle-stick injury, as

staff members needed to use a step-ladder to reach the sharps bins.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Residents were protected by the infection prevention and control policies, procedures and practices in the centre. There was evidence of contingency planning in place for COVID-19. There was infection control guidance and protocols in place in the centre. The inspector observed that the centre was visibly clean throughout the inspection. There were cleaning schedules in place to ensure that each area of the centre was regularly cleaned.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. All staff have received suitable training in fire prevention and emergency procedures. There were adequate means of escape, including emergency lighting. On the first day of inspection garden furniture was seen to block external pathways for exit, this was relocated when the inspector returned on the second day of inspection. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. There was evidence of regular fire evacuation drills taking place in the centre.

Judgment: Compliant

Regulation 6: Health care

The inspector reviewed a sample of healthcare plans and found that they did not appropriately guide the staff team in supporting residents with their health care needs. For example, inconsistencies were found in relation to residents' epilepsy assessment information. A resident's records indicated they had been reviewed by the GP due to suspected seizure activity, however no records of seizure activity had been recorded and the epilepsy management plan stated the last seizure occurred in 2002. The outcome and future plan following the review was unclear for staff. Hospital passports were also found to contain out dated information following discussion with staff.

Evidence of ongoing health checks were not readily available to the person in charge. It was therefore unclear if appointments were attended in line with best practice to ensure residents optimal health. Where engagement in national health screening had been deemed unsuitable for residents, consultation with the resident and rational for not proceeding was not evidenced.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and positive behaviour support guidelines were in place as required. Not all staff had received training in the management of behaviour that is challenging and this has been reflected in the judgment against Regulation 16.

There were systems in place to identify, manage and review the use of restrictive practices. There were a number of restrictive practices in use in the designated centre which had been appropriately identified as restrictive practices. The provider had identified the requirement for review and reduction of restrictions in order to best meet residents' needs.

Judgment: Compliant

Regulation 8: Protection

Notwithstanding issues discussed under Regulation 12 and Regulation 23 residents were protected by the policies, procedures and practices relating to safeguarding and protection. Appropriate measures were in place to keep residents safe at all times. Staff had completed training in relation to safeguarding and protection. Residents had intimate care plans in place which detailed their support needs and preferences.

Judgment: Compliant

Regulation 9: Residents' rights

Overall in the service was striving to provide residents with choice and control across service provision. However, some improvements were required in staff practices observed in order to maintain residents' privacy and dignity. During the inspection, the inspector observed a bathroom door to have been left open while

staff were attending to personal care. While this was a brief incident, the resident's privacy was compromised.

As noted previously, further improvements were required in terms of consultation with residents with regard to finances, healthcare and operation of the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Blossom Hill OSV-0007921

Inspection ID: MON-0031505

Date of inspection: 31/07/2023 and 01/08/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The staffing in the centre will be reviewed by PIC and DOS/ADOS by 29/09/2023, to ensure the appropriate skill mix team are identified to meet the assessed needs of the people supported. Following this review the PIC and ADOS will review Statement of Purpose and update as required. HR are conducting a number of recruitment initiatives, in the first half of October Aurora will be holding an open day, which will be preceded by a radio and social media campaign. Aurora are actively engaging with the Irish Indian community, and are starting to target both the Italian and Polish communities and their local labor markets. Aurora's are also considering a recruitment drive in the Philippines and Singapore, with an aim to commence end of September.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training needs have been identified and scheduled for staff in outstanding area, positive behavior support. This will be delivered by the Behaviour Support Specialist to the staff team by 05/10/2023. The PIC has all mandatory training booked for relevant staff, they will have completed by 06/10/2023. PIC had added Training to agenda of team meeting on 13.09.2023, PIC will	

bring to staff attention the importance and benefits of attending training as identified.

Supervision schedule is up to date (31.08.203), this is filed in QC folder and dates are reflective of planned QC till year end.
PIC will monitor and report in PIC monthly status report that is sent to DOS & ADOS.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PIC has monthly team meetings scheduled till year end; all staff are encouraged to attend if not available they will sign off on minutes of team meeting. Audits and actions outstanding to be discussed at next team meeting and at all team meetings going forward. September meeting scheduled for 13.09.2023

Quality Conversations are scheduled for the year as per policy and will be completed by PIC as per schedule.

Audit folder in place and action plans from audits to be discussed at team meeting on 13.09.2023 and reviewed at quality conversations, audits are on team meeting agenda.

QA have reviewed the audit schedule and audit tools; the annual review template has been updated. The Lead auditor will lead out on completing review to include getting feedback from people supported and their families.

QA have sent out satisfaction surveys to people supported and their families on 26/07/2023. Report will be developed on results of survey which will be made available to people supported and families to view.

The TIC process was discussed at Safeguarding Oversight Committee meeting on 09.08.2023, it was agreed to form a working group that would review the process and cases presented by 01.10.2023

As per Personal Plan policy Circle of Support facilitator have facilitated 3 Annual Review Visioning Meeting and fourth one schedules for 16.11.2023.
Reviews are completed on a monthly basis
Weekly Focus on Future meeting are held in the centre this provides opportunity to plan for each person supported appointments & roles to be supported over the following week.

PIC will monitor through weekly governance and reports on all of the above to the DOS & ADOS through the PIC monthly report

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of purpose has been reviewed in relation to staffing compliment and provided has submitted to inspector.

QA department submitted the Statement of purpose to regulator on 04/08/2023 and at HIQA request resubmitted again on 21/08/2023.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In going forward PIC will ensure that all notification of incidents will be submitted in line with specified timeframe as outlined in HIQA Monitoring notifications handbook.

The provider has developed a process to monitor and check on quarterly notifications being submitted within relevant timeframes. Notifications will be sent from the QA department as a reminder to all PIC and Team Leaders to submit quarterly notifications. The QA department have developed a Ways of Working and sent to PIC, Team Leads and staff teams high lightening the notifications and associated timelines.

PIC will hold oversight of incidents & notification using the PIC local governance report, and then PIC will report on incident/notifications to DOS & ADOS through PIC monthly report.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
PIC will oversee a full review of people supported personal possessions and Assets list, this will be completed by 15/09/2023 by keyworkers/keyteams.

All people supported have an asset list and this has been added to
(i) Finance section on Annual Review Visioning Meeting template to ensure individuals assets are reviewed annually, it has also been added to
(ii) Monthly Review template to ensure checks are completed on a monthly basis.

In June 2023 Aurora Finance department commenced the roll out of a new debit card, Soldo as Quality Initiative (QI) across all designated centres this is in regards to their house budgets. This QI has been monitored and measured and any identified improvement implemented

The next development of Soldo cards will be implemented for people supported, it is anticipated that people supported soldo card will be rolled out by 13.10.2023

Finance Department has reviewed the Residents personal property, finances & possessions Policy.

A new form "Entitlements, Income and Expenditure Form" has been issued across the service on 01.09.2023, this will be completed for each person supported by 20.09.2023 and will be filed as page 1 in person supported finance folder. This form will provide an over view of person supported finances, and will be included in audits.

PIC will discuss Residents personal property, finances & possessions policy at staff team on 13.09.2023

Aurora developed a Finance Position Paper in February 2023 to outline the challenges re person's bank accounts. This position remains and has been made available to HIQA in February 2023.

Finance Department have identified an experienced member of the team to complete audits on provider level to ensure further oversight. PIC will complete monthly finance audits.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
PIC will complete by 11.09.2023 a Risk assessment and SOP around lone working in the activity room, a mobile phone has been identified as a control measure, the phone and charger will remain in this room, by

Sharps bins have now been removed and disposed of in a correct manner. New appropriate size sharp bin will be sourced by 15.09.2023 and stored in locked medication

press.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Hospital passport was reviewed by staff Nurse, to be completed by 08/09/2023.

One person supported has now been registered 06.09.2023 for breast check screening program again and is awaiting an appointment. Social Stories will be developed to provide person supported with information on procedure.

Appointment was made for 07.09.2023 for resident to be reviewed by GP on in regards to possible seizure activity. Following on from GP review the Epilepsy plan and all relevant paperwork will be updated to reflect GP's recommendation, complete by 15.09.2023

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Supervision with staff member in question took place with PIC on 08.09.2023 around dignity and respect of people supported.
The learning from this incident to be brought to next team meeting for all team members, refocus on FREDA principles.

All staff team have completed the four modules on Human Rights, they will now be asked to complete a module and Fundamentals of Advocacy by 29/09/2023.

PIC will discuss at team meeting on 13.09.2023 the importance of consultation with people supported using a total communication approach.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	20/09/2023
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	29/09/2023
Regulation 16(1)(a)	The person in charge shall	Substantially Compliant	Yellow	06/10/2023

	ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	08/09/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/09/2023
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	07/09/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of	Substantially Compliant	Yellow	08/09/2023

	risk, including a system for responding to emergencies.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	21/08/2023
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	22/08/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	07/09/2023
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his	Substantially Compliant	Yellow	13/09/2023

	or her care and support.			
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	13/09/2023