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:	Teach Sona
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	29 August 2022
Centre ID:	OSV-0007991
Fieldwork ID:	MON-0033164

About the designated centre

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

Teach Sona is a centre run by the Health Service Executive. The centre provides residential care for up to four male and female adults, who have an intellectual disability and mobility needs. The centre is a single storey dwelling in Co. Donegal, providing residents with their own bedroom and is also wheelchair accessible. There is provision for nursing hours and three staff, including two health care assistants are on duty during the day and two staff on duty during night time hours.

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 29 August 2022	10:30hrs to 16:45hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This centre is run by the Health Service Executive (HSE) in Community Healthcare Organisation Area 1 (CHO1). Due to concerns about the management of safeguarding concerns and overall governance and oversight of HSE centres in Co. Donegal, the Chief Inspector of Social Services undertook a review of all HSE centres in that county. This included a targeted inspection programme which took place over two weeks in January 2022 and focused on Regulation 7: Positive behaviour support, Regulation 8: Protection and Regulation 23: Governance and Management. The overview report of this review has been published on the Health Information and Quality Authority (HIQA) website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Donegal. It should be noted that although this centre is located in Co. Donegal, it is governed by the HSE services in Sligo/Leitrim.

The centre consisted of a large bungalow located at the edge of a town. Each resident had their own bedroom, all of which were decorated in different styles as chosen by the residents. One bedroom had an en-suite bathroom. The shared rooms in the house consisted of two sitting rooms, a kitchen-dining room, two bathrooms with level access showers, a utility room and a number of store rooms. The house had a pleasant, homely atmosphere. It was nicely decorated throughout with new, comfortable furniture. The house was in a good state of repair and was fully accessible. One sitting room was equipped with sensory lighting and equipment. It also had a coffee maker as one resident enjoyed relaxing in that room while they made coffee. Residents had profiling beds, if required, and specialised seating. Outside, the grounds were nicely maintained. There were benches and wheelchair accessible picnic tables for use by the residents. All entrances to the centre were fully accessible for residents with limited mobility. Closed circuit television (CCTV) cameras were located at various points around the building and the images from the cameras were shown on a loop on a screen in one of the sitting rooms. The cameras were set up to monitor the outside of the building for security purposes. However, the inspector noted that some of the cameras were angled so that some of the images included the interior of the building. One camera captured part of a sitting room. Part of a resident's bedroom was captured by another camera and a third camera included the windows of two other bedrooms. This will be discussed later in the report.

The residents had been living in the centre for just over one year. They had moved from a congregated setting in Co. Sligo and were known to one another before moving to their new home. The inspector had the opportunity to meet with three of the four residents on the day of inspection. One resident was staying with family

members. Residents spent the day in different parts of the house and appeared happy and relaxed in their home. One resident left the centre for a period of time to go on an outing. Staff supported residents to chat to the inspector and residents engaged with the inspector on their own terms. When asked, one resident said that they were happy in their home. The inspector had the opportunity to attend part of the residents' weekly meeting. Residents were given the opportunity to choose activities that they would like to do at the weekend and to make choices about their meals for the week.

Staff were friendly and caring in their interactions with residents. They were observed offering choices to residents and those choices were respected. Staff were knowledgeable on the needs and preferences of residents. Staff responded when residents asked for help. They were respectful when they spoke about residents.

Overall, residents were in receipt of a good quality service in this centre. Staff supported residents with their health, social and personal care needs. While residents were offered choices and treated with dignity, improvement was required in relation to the respect of residents' privacy. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

As outlined above, this centre was located in Co. Donegal. However, its governance was through the HSE services in Sligo/Leitrim as residents had moved from a congregated setting in Co. Sligo. Therefore, the compliance plan submitted following the targeted inspections in Co. Donegal in January 2022 was not applicable in the same manner in this centre. However, comparable governance structures and oversight arrangements were in place for this centre and within Sligo/Leitrim services. The person in charge was on leave on the day of inspection and the inspection was facilitated by the person in charge of another centre from within the Sligo/Leitrim services. A member of senior management also provided information on the day of inspection in relation to senior management meetings and governance structures within the service. The inspector contacted the person in charge of Teach Sona when they returned from leave to gather further information and to confirm details obtained on the day of inspection.

There were robust governance and oversight arrangements in the centre that mirrored the arrangements outlined in the CHO1 compliance plan. Senior management held weekly governance meetings. These meetings were attended by disability managers and clinical nurse managers (CNM) 3 from across the Sligo/Leitrim services. It was reported that a representative from senior management in Co. Donegal had attended the most recent governance meeting held in Sligo/Leitrim the previous Friday. Information from these meetings was

shared with persons in charge at the fortnightly meeting between all persons in charge within Sligo/Leitrim services. Again, this was comparable to the arrangements that had been introduced in Co. Donegal. The person in charge reported that this fortnightly meeting was useful for shared learning across centres. There was also a Policy Procedure Protocol and Guidelines (PPPG) Group and Human Rights Committee in existence within the service. The person in charge reported that safeguarding was discussed at the Incident Review Group. This meeting occurred on a monthly basis and included a review of all incidents that occurred in designated centres within the service, including any incidents relating to safeguarding. Within the designated centre, staff meetings occurred on a regular basis and minutes were shared with all staff. The person in charge reported that there was a flow of information between staff meetings held in the designated centres, to the meetings between persons in charge and onward to senior management.

As part of the compliance plan for CHO1, the provider had committed to reviewing the audits used in designated centres in the county. New audit tools and a new audit schedule had been devised and this was introduced in this centre from 1 August 2022. The audit schedule included 16 different audit tools that were due for completion on a monthly, bi-monthly, quarterly or annual basis. Audit findings were included on a quality improvement plan for the centre. The plan outlined the actions within a specific timeframe that were needed to address the issues found on audit. As the audit schedule had been newly introduced, it required additional time for its effectiveness to be established. The inspector noted that the existing audit tool for CCTV cameras was not adequate as it had not identified that cameras were capturing footage of interior rooms in the centre. This was not in line with the provider's own policy that stated that CCTV cameras 'shall be placed in a manner that ensures they do not intrude on the privacy of the individual'.

The provider had completed six-monthly unannounced audits and an annual review into the quality and safety of care and support in the centre. Where it was identified that service improvements were required, the provider had identified goals to address these issues. However, some of the goals devised in the report were not sufficiently detailed to guide service improvement. In addition, the provider had not always adhered to the timelines set out for these goals. For example, the provider had set a goal of discussing the CCTV cameras with residents and providing an easy-to-read policy document in relation to CCTV by 30/07/2022. However, this had not occurred on the day of inspection. This will be discussed later in the report.

The staffing arrangements and staff rosters in the centre were reviewed. The staffing arrangements in the centre were adequate to meet the assessed needs of residents. Nursing support was available in the centre during the day and on-call nursing was available overnight. Agency staff were employed in the centre. However, these were regular staff who were familiar to the residents and ensured that there was a continuity of care for the residents.

The person in charge maintained an overview record of staff training. This was not accessible on the day of inspection as the person in charge was on leave. The person in charge provided details of staff training to the inspector when they

returned from leave. The provider had identified 31 mandatory training modules for staff and an additional 13 modules that were specific to staff working in this centre. A sample of training records found that all staff were up to date on training in relation to safeguarding, Children First, cardiopulmonary resuscitation and hand hygiene. One staff member was scheduled to attend training in relation to manual handling in the coming weeks. Not all staff were fully up to date in all mandatory training modules. For example, three staff required training in managing behaviours that are challenging and two staff needed training in infection prevention and control basics.

Overall, there were clear lines of accountability and defined management structures in this centre. Information was relayed across the service to facilitate shared learning. The staffing arrangements in the centre were adequate to meet the assessed needs of residents. However, improvement was required in relation to staff training. Improvement was also needed to ensure that audits identified all areas for service improvement and that identified service improvement goals were clearly defined.

Regulation 15: Staffing

There were adequate staffing arrangements in the centre to meet the assessed needs of residents. The person in charge maintained a planned and actual staff roster. Agency staff who were employed in the centre were familiar to the residents, ensuring continuity of care.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified 31 mandatory training modules for staff. There were also 13 site-specific training modules for staff in this centre. Records indicated that some staff required refresher training in some mandatory modules. Staff were also not up to date with their training in the site specific modules.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance

meetings at county, network and centre level and one action related to a review of audits within CHO1. As discussed, although this centre was located in Co. Donegal, it was governed by the HSE services in Sligo/Leitrim. The person in charge reported that the governance meetings outlined in the compliance plan were, therefore, not entirely relevant to this centre. However, comparable governance meetings were in existence within the Sligo/Leitrim service and covered the ten areas outlined in the CHO1 compliance plan. Senior management governance meetings occurred on a weekly basis. Persons in charge met on a fortnightly basis. Staff meetings happened regularly in the centre. There was evidence that information was shared across the service and escalated to senior management when required.

Within the centre, the new audit tools and schedule outlined in the provider's compliance plan had been devised and implemented on 1 August 2022. As this had been newly introduced, additional time was required in order to determine the effectiveness of the audits. The existing audit tool in relation to CCTV had not identified service improvement issues that were noted on inspection.

The provider had completed six-monthly unannounced audits and an annual review of the service. However, some of the service improvement goals devised from these reports were not specific. In addition, the provider had not adhered to all of the timelines set out in the reports. For example, the provider had set a target date of 30 July 2022 to provider residents with easy-to-read information in relation to the CCTV policy. However, this had not occurred on the day of inspection.

Judgment: Substantially compliant

Quality and safety

Residents in this centre received a good quality service. The centre itself was a pleasant building and accessible for all residents. Residents were supported to engage in activities of their choosing and were routinely offered choices throughout the day. However, improvement was required in relation to the protection of residents' privacy and the identification of risks to residents.

The centre itself was a pleasant home. The house was fully accessible to all residents. It was clean, tidy and nicely decorated. Rooms were personalised with the residents' objects and photographs. There was adequate space for residents to spend time together or alone. There was ample storage for residents' personal possessions. The building was equipped with the equipment and facilities required by the residents. For example, residents had profiling beds if required. The inspector also noted that the kitchen was stocked with ample fresh food for meals, snacks and refreshments. Residents were supported to go grocery shopping and prepare meals, if they wished. Choices at mealtimes were available for all residents. Some residents had specific recommendations in relation to modified consistency foods. Staff were knowledgeable on these recommendations and on how to prepare foods to the

appropriate consistency for residents.

The inspector reviewed a sample of the residents' personal plans. Residents' health, personal and social care needs were assessed within the last 12 months. Where a specific need was identified, a corresponding care plan had been written to guide staff on how to support residents. The care plans were regularly reviewed and updated. Residents' plans contained personal goals and there was evidence of the progress that residents were making towards the achievement of those goals. Residents had an annual review of their personal plans. These review meetings were multidisciplinary and included members of the residents' family. There was evidence in the plans that the residents' healthcare needs were well managed. Residents had a named local general practitioner (GP). There was evidence that residents had access to a wide variety of healthcare professionals. Each personal plan contained a detailed medical history and there was evidence of follow-up with medical appointments. There was clear guidance to staff on how to manage the residents' medical needs. For example, the protocol for the administration of emergency medication for one resident in the event of a seizure was clearly outlined.

Where required, residents' personal plans contained behaviour support plans. These had been devised by a relevant healthcare professional. The plans gave information of the residents' specific behaviours. It outlined how to support residents to remain calm and how to support them if they became upset or anxious. Supporting residents manage their behaviour was included in the provider's compliance plan for CHO1. This included plans to recruit psychologists, social workers and speech and language therapists. There was evidence in this centre that residents had access to these services. The person in charge also reported that each centre had its own induction checklist specific to the needs of residents in that centre.

Residents in the centre had a good quality of life. A review of daily notes showed that residents were supported to engage in activities of their choosing. Some of these activities happened within the centre, for example, baking, beauty treatments and sensory activities. Other activities ensured that residents were supported to access the wider community. For example, some residents were members of a local walking group and others enjoyed growing vegetables in an allotment. Residents enjoyed trips to religious sites and meals out. They were supported to maintain good links with family and friends. Residents were routinely offered choice in their daily lives and this was observed during the inspection. Residents were supported to be active participants in the running of the centre. The inspector observed the weekly residents' meeting where the residents chose the meals for the week ahead and the places that they would like to go. A review of the minutes of these meetings showed that residents were provided with information in relation to advocacy and the complaints procedures in the centre. However, the provider had failed to protect the residents' right to privacy through the use of CCTV in the centre. Of significant concern, the cameras captured footage within one resident's bedroom. Residents had not been informed of the use of CCTV. On the day of inspection, easy to read information was made available for residents at their meeting. However, this information was not specific to the centre and did not outline the specific locations of the cameras in the centre.

Residents in the centre were protected from abuse. Staff were fully trained in safeguarding and knowledgeable on what steps to take if they had any safeguarding concerns. There were no open safeguarding plans in the centre on the day of inspection. There was evidence that previous safeguarding incidents and plans had been reported and escalated as required. The CHO1 compliance plan outlined a number of actions that would strengthen the governance arrangements in relation to safeguarding. There were similar governance arrangements in existence in this service. As mentioned previously, persons in charge attended monthly incident review meetings. Safeguarding incidents and plans were reviewed at these meetings. This allowed for shared learning between centres and safeguarding plans could be updated based on input from colleagues. A member of senior management reported that there were monthly meetings between disability managers and the safeguarding team. Safeguarding was also included on the agenda of the weekly governance meetings. The person in charge in the centre had completed Sexuality Awareness in Supported Settings (SASS) training. However, no other staff members in the centre had received this training. In addition, the policy for safe WiFi usage had yet to be completed and there was no risk assessment in the centre relating to the use of the internet by residents in the absence of this policy.

The arrangements for the management of risk was reviewed. Residents had individual risk assessments in their personal plans. These identified the risks to residents and the control measures that should be in place to reduce those risks. The risk assessments were regularly reviewed. The person in charge also maintained a risk register for the centre. This identified risks to the service as a whole. Risks were specific to the centre and assessments were regularly reviewed and updated. However, the risk to residents' privacy from the use of CCTV cameras had not been identified or assessed.

Overall, the centre provided a good quality service to residents. The robust governance systems ensured that residents were protected from abuse and they were supported to engage in meaningful activities within the centre and in the wider community. Improvement was required in relation to the protection of resident's privacy and the assessment of risk.

Regulation 13: General welfare and development

The residents in this centre were supported to engage in activities that were in line with their interests. This included activities within the centre and within the wider community. They were supported to maintain links with family and friends through phone calls and regular visits.

Judgment: Compliant

Regulation 17: Premises

The premises were suited to the needs of residents. The building was fully accessible and equipped with the facilities required by residents. Residents had their own rooms that were personalised with their own choice of decor and photographs. There was adequate room for residents to spend time together or alone as they wished. The centre was in very good decorative and structural repair.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were provided with ample fresh food for meals, snacks and refreshments. They were offered choices in relation to their meals. Meals were home-cooked and nutritious. Staff were knowledgeable of the residents' specific needs in relation to their eating and drinking. Staff could prepare food and fluids to the correct consistency for residents. Residents were supported to go grocery shopping if they wished.

Judgment: Compliant

Regulation 26: Risk management procedures

There were individual risk assessments for residents in this centre. These assessments identified risks to residents and the control measures that should be implemented to reduce the risks. The person in charge also maintained a risk register in the centre that identified risks to residents, staff, visitors and the service as a whole. Risk assessments were regularly reviewed. However, not all risks identified on inspection had a corresponding risk assessment.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' health, social and personal needs were assessed within the last 12 months. Residents had a personal plan in place that outlined the supports needed to assist residents meet these needs. The personal plan was reviewed annually. This review assessed the effectiveness of the plan and outlined ways that the residents could further their personal development.

Judgment: Compliant

Regulation 6: Health care

Residents' healthcare needs were well managed. Residents had access to a wide range of healthcare professionals as required. There was evidence of follow-up on medical appointments and healthcare recommendations.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed, through its compliance plan, to complete seven actions aimed at improving governance arrangements relating to positive behavioural support at the centre. Comparable governance arrangements were in place in this centre within the Sligo/Leitrim services that accounted for these seven actions. Residents had access to relevant healthcare professionals to support them manage their behaviour. Where required, residents had behaviour support plans in place. Staff training was included on team meeting agendas. Staff were knowledgeable on the supports required by residents to manage their behaviour.

Judgment: Compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed, through its compliance plan, to complete 13 actions aimed at improving governance arrangements relating to protection of residents. The inspector reviewed 12 of these actions on the day of inspection. Comparable governance arrangements were in place in this centre within the Sligo/Leitrim services. These arrangements accounted for 10 of the actions outlined in the compliance plan and these were well-established in this service. Safeguarding incidents and plans were reviewed through regular governance meetings between persons in charge and at senior management meetings. There was shared learning between centres. All staff in the centre were trained in safeguarding. There were no open safeguarding plans in the centre on the day of inspection. There was evidence that previous safeguarding incidents and plans had been processed and escalated appropriately. However, two of the actions outlined in the CHO1 plan had not yet been completed in the centre. Staff had not received SASS training. In addition, the policy for safe WiFi usage had not yet been

devised and there was no risk assessment to guide staff practice in this regard.
Judgment: Substantially compliant
Regulation 9: Residents' rights
Residents were routinely offered choice in this centre. These choices were respected. Residents were treated with dignity and respect. However, the residents' right to privacy was significantly impacted as CCTV cameras recorded private areas of the centre and residents had not been made aware of this.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Teach Sona OSV-0007991

Inspection ID: MON-0033164

Date of inspection: 29/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person In Charge has ensured all Refresher training has been carried out for all Mandatory Training as required, there is now a training schedule in place for refresher training. This has been Completed 06/10/2022 • The Person In Charge has a training plan in place, for all the site specfic training, identified during the Inspection to be completed. The Person in Charge has ensured and Identified additional support for Staff to complete their refresher and Mandatory training as required. This has been completed 06/10/2022	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Registered Provider has ensured that Management Systems are now in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and are effectively monitored. • The Person in Charge in collaboration with the Regional Director has reviewed the Security and Building Access with the Use of Closed Circuit CCTV Audit tool, which now	

includes service improvements identified on the day of Inspection. Completed 03/10/2022.

• The Person in Charge in collaboration with Staff, Residents and Speech and Language Therapist has now developed a Site Specific easy read tool to support residents in their understanding around the use of CCTV outside their home. Completed 03/10/2022

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Registered Provider has ensured that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

• The Person in Charge has completed two Risk Assessments which now reflects the controls in place around, the Use of Internet Wi-Fi and the Use of Security CCTV in relation to Dignity, Privacy and Respect of the resident. Completed 29/09/2022.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Registered Provider has ensured that robust management systems are now in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

• The Registered Provider shall protect residents from all forms of abuse in relation to Safeguarding incidents through regular governance meetings between persons in charge and senior management.

• The Person In Charge ensures shared learning between centres. All staff in the centre are trained in safeguarding. There were no open safeguarding plans in the centre on the day of inspection

• The Person in Charge in collaboration with the Regional Director and the Policy Group, will develop a Policy on" Safe Use of Wi-Fi/Internet" to meet the needs of Residents

safety, for the CHO1 Area. This will be approved by the Register Provider and circulated to all staff within the Designated Centre.

• The Person in Charge has a plan in place for all site specfic trainng needs identified on the day of the Inspection in this Deignated Centre, this Includes Sexuality Awareness in a Support Setting(SASS) training. In order to complete the roll out of training a target date of 31/12/2022 has been set.

• The Person in Charge has completed two Risk Assessments which now reflects the controls in place around, the Use of Internet /Wi-Fi and the Use of Security CCTV in relation to Dignity, privacy and Respect of the resident to guide staff practices. Completed 29/09/2022.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Registered Provider has ensured that the management systems are now in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. The Registered Provider has ensured that the Rights of the Residents are upheld.

• The Person in Charge in collaboration with the Regional Director and the Policy Group, will develop a Policy on" Safe Use of Wi-Fi/Internet" to meet the needs of Residents safety, for the CHO1 Area.This will be approved by the Register Provider and circulated to all staff within the Designated Centre

• The Person in charge contacted the CCTV Company who have adjusted the camera/Visual Unit view to ensure the right to privacy for all residents in this Designated Centre is upheld. Completed 30/09/2022

• The Person in Charge has completed a Risk Assessments which now reflects the controls in place around, the Use of Security CCTV in relation to Dignity, Privacy and Respect of the residents in this Centre. Completed 29/09/2022

• The Person in Charge in collaboration with the Regional Director has reviewed the Security and Building Access with the Use of Closed Circuit CCTV Audit tool, which now includes service improvements identified on the day of Inspection .Completed 03/10/2022

• The Person In Charge has a plan in place for all site specfic trainng needs identified on the day of the Inspection, this Includes Sexuality Awareness in a Support Setting(SASS) training for this Designated Centre. In order to complete the roll out of training a target

date of 31/12/2022 has been set
• The Person in Charge in collaboration with Staff, Resident and Speech and Language Therapist has now developed a Site Specific easy read tool to support residents understanding around CCTV outside their home. Completed 03/10/2022

• The Policy in relation to the use of CCTV cameras and Audit tool is in place in this Designated Centre. All staff has been refreshed on this policy at a Team Meeting on the 05/10/2022. Completed 05/10/2022

• Easy read Tool will be Incorporated into Residents next meeting. Completed 05/10/2022

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 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.	Substantially Compliant	Yellow	31/10/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	03/10/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	29/09/2022

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	06/10/2022
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.	Not Compliant	Orange	31/12/2022