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:	Goldfinch 6
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	27 July 2022
Centre ID:	OSV-0008268
Fieldwork ID:	MON-0037235

About the designated centre

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

Goldfinch 6 is a semi-detached two-storey house located in a housing estate on the outskirts of a city. The centre is intended to provide temporary residential services for a maximum of four residents of both genders, over the age of 18 with intellectual disabilities. Support to residents is provided by the person in charge, a team leader and social care workers. Four bedrooms are provided in the centre for individual residents and other facilities include bathrooms, a living room, a kitchen/dining room, a living room, a sunroom and a staff room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Wednesday 27 July 2022	09:20hrs to 16:05hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Staff members present were seen to interact with residents in an appropriate and respectful manner. While parts of the premises provided for residents to live in were seen to be clean, homely and well-furnished, some areas were also found to require further cleaning and maintenance.

Four residents were living in the designated centre but on the day of inspection only two of these residents were present while the other two residents were staying with family members. Shortly after the inspection commenced the inspector met one the residents present. This resident greeted the inspector by touching elbows and then left the centre to go for a walk independently. On their return to the centre the resident told the inspector that they were doing some cleaning of their bedroom.

The second resident present was also met by the inspector. This resident did greet the inspector but did not engage with him beyond this. It was seen though that this resident talked with staff members present about shopping and about the staff that would be on later in the day. Staff on duty were seen and overheard to interact appropriately with both residents and to be respectful towards them. For example, one staff member knocked on a resident's bedroom door and waited for a response before opening. In the afternoon of the inspection, the two residents left the centre with staff to go for a drive and to get a meal out.

Residents and staff returned to the centre towards the end of the inspection. A staff member told the inspector that they had gone to a restaurant with one resident indicating to the inspector that they had gotten a salad while they had been out. When asked by the inspector how they would be spending the rest of their day, the resident said that they would be meeting a family member. When asked by the inspector how their day had been, the second resident did respond to this but spoke with staff about shopping and the staff that would be on later in the day. Staff responded pleasantly to the resident's queries.

Aside from this there were indications that residents were being given information about the running of the centre. For example, in the dining area a sign was on display showing a photo of a new staff member who was due to start working in the centre the week after this inspection. Resident meetings were also taking place on a regular basis which were facilitated by staff members. Notes of such meetings reviewed by the inspector indicated that topics discussed with residents included activities, fire safety and complaints. A complaints logs reviewed indicated that no complaints had been made since residents moved into this centre. While information on the complaints process was on display in the centre's dining area.

Various other information were displayed around the centre including signs on hand washing, COVID-19 and fire safety. It was also seen that a number of a framed photographs of residents were on display throughout the communal areas of the centre which were also well-furnished. This contributed to the centre having a

homelike feel. All four residents living in this centre had their own bedrooms and it was seen that these were well-furnished and personalised with some items seen in these being televisions, a games console, family photos and awards residents had received. Such bedrooms also had facilities available for residents to store their personal belongings such as wardrobes.

Despite this, it was seen that space in the centre appeared limited in some aspects. For example, it was observed that an area designated as a sunroom was primarily being used for storage purposes with items such as food, cleaning supplies, an ironing board and tools seen to be kept there during the inspection. It was also noted that both the centre's statement of purpose and residents' guide described the centre as having a large enclosed garden but on viewing the garden provided, this description was inaccurate.

The centre was also observed to be generally well-maintained, but it was seen that some external window sills appeared cracked while some dead ants were seen around one door frame. Large parts of the centre were also found to be clean on the day of inspection while a staff member was observed doing some cleaning during the early part of the inspection. However, during the inspection it was seen that two toilet seats in bathroom used by residents were noticeably worn. One of these toilet seats was also visibly unclean while some of the taps in some bathrooms were also found to require further cleaning.

In summary, some areas of the premises provided for residents needed further cleaning and maintenance. Despite this it was seen that residents had their own personalised bedrooms while communal areas of the centre were homelike. Residents were being provided with information with respectful and appropriate interactions observed between staff members and residents on the day of inspection.

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.

Capacity and capability

Staffing levels had increased in this centre since it had first been registered but night-time staffing arrangements required review. A statement of purpose and a directory of residents were in place but both required updating in some areas.

This designated centre was first registered by the Health Information and Quality Authority (HIQA) in June 2022 for three years. The intended purpose of this centre was to provide a temporary home for residents in some of the provider's other centres in the Limerick area to allow fire safety upgrades works to be completed in those other centres. Shortly after the current centre was registered, HIQA were

informed that three residents from another of the provider's centres had temporarily moved into this centre for this reason. These resident remained in this centre and as such the purpose of the current inspection was to assess compliance with relevant regulations since these residents had begun living in the centre.

In keeping with the requirements of the regulations, a statement of purpose was in place for the centre. This is an important governance document which sets out of the purpose and function of the centre along with the services and facilities to be provided to residents. The statement of purpose also forms the basis of a condition of registration. It was seen that the centre's statement of purpose contained much of the information required by the regulations but that it had not been updated to reflect all of the information as outlined in the centre's certificate of registration. In addition, it was noted that the statement of purpose did not fully reflect the intended purpose of this centre for its current registration period as mentioned earlier.

The statement of purpose did include details of the staffing arrangements in place and the inspector was informed that additional staffing had been made available for the residents in the centre at the time of inspection with this increased staffing to remain in place once the residents returned to their normal home. This was a positive development given the changing needs of one resident with a fourth resident also having been admitted to the centre since the first three residents came to the centre. However, during nights only a sleepover staff was present in the centre and a log maintained indicated that one resident was getting up during some nights. This was related to the changing needs of the resident. As such the night-time staffing arrangements provided required review. This would apply for the remainder of these residents time in this centre or when they returned to their usual home.

The residents that live in any designated centre should be included in a specific directory of residents as required by the regulations. Such a directory was provided for this centre but it was noted that it did not include the most recent resident who had come to live in this centre while for the other residents, their dates of admission to this centre were not indicated. Given the length of time the centre had been operational for, a provider unannounced visit to the centre had not been completed at the time of this HIQA inspection. Such visits are required by the regulations and form part of the monitoring systems to review the quality and safety of care and support provided to residents.

The provider had arrangements in place to ensure that such visits would be carried for this centre at six monthly intervals as required by the regulations. Despite this, a number of regulatory actions were identified on this HIQA inspection in areas such as personal planning, infection prevention and control, fire safety and risk management. As such the inspector was not assured that the provider's current monitoring systems were identifying all issues in a timely manner. It was noted though that the provider had established an on-call system which operated to enable staff to sneak assistance or additional guidance if needed outside of regular working hours. A staff member spoken with was aware of this while contact details

for the on-call system were present in the centre.

Regulation 15: Staffing

Rosters were maintained for the centre while staffing had increased for the residents currently living in this centre. However, given the changing needs of one resident, night-time staffing arrangements required review.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was in place but it did not contain one of the residents in the centre while other residents' dates of admission to this centre were not stated.

Judgment: Substantially compliant

Regulation 23: Governance and management

An on-call system was available for staff to seek guidance from while arrangements were in operation to ensure that the centre received a provider unannounced visit every 6 months. Given the number of regulatory actions identified on this inspection, the provider's current monitoring systems were not identifying all issues in a timely manner.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was in place but it did not include all of the information as outlined in the centre's certificate of registration. The statement of purpose did not fully reflect the intended purpose of this centre. A section in the statement of purpose on the facilities of this centre indicated that it had "a large enclosed rear garden" however this was not accurate.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Complaints were discussed with residents during regular resident meetings while information on the complaints procedure was on display in the centre. A process was available for any complaints made to be recorded.

Judgment: Compliant

Quality and safety

Staff members were provided with relevant training in areas such as fire safety and safeguarding. While residents did have personal plans provided for, some improvement was needed regarding assessments of need and the contents of some personal plans. Cleaning practices in the centre also needed review and improvement.

Under the regulations, all residents should have a personal plan which is to be informed by a comprehensive assessment of needs completed prior to admission to a centre, on an annual basis or to reflect changes in circumstances. Such plans should also reflect residents' assessed needs and how to provide for these. Residents of this centre did have personal plans but it was noted that the most recent resident who was admitted to the centre did not have a complete personal plan finalised at the time of inspection. For example, sections on the resident's health needs and the resident's safety had not been completed. In addition, while it was acknowledged that there were particular circumstances behind this resident's admission to this centre, it was noted that the most recent assessment of need available for this resident was from January 2018.

When reviewing the personal plan for another resident, a psychology report from February 2022 was reviewed which highlighted a need to review the services provided for this resident to better meet their needs. Despite this a comprehensive assessment of needs for this resident had not been completed since while it also seen that the resident's personal plan contained limited guidance on specific interventions to support some of the resident's assessed needs. While these were areas that required improvement, it was noted the changing needs of one resident and the background of the most recent admission were well known to management of the centre while processes were in operation for residents and their personal plans to be reviewed by a multidisciplinary team of health and social care professionals when required.

Most residents' personal plans contained specific individual risk assessments for identified risks. These assessments outlined the nature of such risks and provided details of measures to take to reduce the chance of the risk occurring. The inspector

viewed a sample of such risk assessments and noted them to have been recently reviewed. It was seen that the review of some risk assessments related to the changing needs of one resident was influenced by recorded incidents in the centre. However, as mentioned earlier a log was maintained recording instances where one resident had gotten up at night. There were four entries on this log for July 2022 and the inspector was informed that all should have been logged as an incident for review but that no incident had been recorded for this centre since residents moved in during June 2022. As such while the relevant risk assessments had been recently reviewed, they did not take account of all relevant occurrences in the centre.

A centre specific risk register was in place which had been recently reviewed but it was noted that it did not contain a risk assessment relating to fire. However, it did contain a risk assessment related to infection prevention and control and during this inspection it was seen that measures were in place to promote effective infection prevention and control practices in some areas. For example, supplies of personal protective equipment and hand sanitisers were present in the centre while staff were seen to wear face masks throughout the inspection. Cleaning products such as mops were also provided for but early on in the inspection, the inspector observed one mop head left on one of the bathroom floors. This mop head was visibly unclean but towards the end of the inspection it was seen to have been washed and moved to the sunroom for storage.

To support cleaning efforts in the centre a specific COVID-19 cleaning checklist was provided for. This outlined specific cleaning tasks that were to be completed on a daily basis including the cleaning of frequently touched items, like handles and taps, and the mopping of floors. However, on the day of this inspection the last COVID-19 cleaning checklist completed was from 17 July 2022 while there was inconsistencies in the checklists completed before then. For example, on some days the mopping of floors was indicated as being done while on others it was not. Another weekly cleaning schedule was in place in this centre but it was found that this was specific to another house in a different designated centre.

While large parts of the current centre were seen to be clean on the day of inspection, as highlighted earlier some taps in the centre and the toilet seat in one bathroom required further cleaning. The inspector was informed that only one resident used this bathroom but this resident had not been in the centre since the previous week. Taking into account such matters and the cleaning documentation presented on the day of inspection, this did not provide assurance that clear, consistent and effective cleaning practices were being followed in this centre. Such practices are important from an infection prevention and control perspective. During the feedback meeting for this inspection, the inspector was informed that the toilet seats highlighted in this inspection report would be replaced the day after this inspection.

Records provided indicated that staff had undergone training in areas such as infection prevention and control, safeguarding and fire safety. A fire drill had also been completed since residents moved to the centre with a low evacuation time recorded while the centre had been provided with fire safety systems including a fire alarm, emergency lighting and fire extinguishers. Such systems had been recently

serviced by external contractors to ensure that they were in proper working order. Fire doors were also present in the centre with such doors being important to prevent the spread of fire and smoke in the event of fire. Shortly after the inspection commenced, the inspector observed one fire door that was held open by a wedge. While this wedge was removed soon after by a staff member and no fire door was seen to be held open for the remainder of the inspection, the wedging open of doors in this manner would prevent them from operating as intended.

Regulation 12: Personal possessions

Residents were provided with facilities to store their personal belongings but it was noted that a personal possessions list for one resident had not been completed in full.

Judgment: Substantially compliant

Regulation 17: Premises

While the centre was generally seen to homely and well-furnished, maintenance was required in some areas. For example, some external windows sills were cracked while some toilet seats were noticeably worn.

Judgment: Substantially compliant

Regulation 20: Information for residents

A residents' guide was in place that contained required information such as details around visiting and how to access HIQA inspection reports. The guide also contained a summary of the services and facilities provided but this indicated that the centre had a large enclosed garden. However, this was not accurate.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Matters which were indicated as requiring to be recorded as an incident were not being recorded as such which impacted the risk management process. A centre

specific risk assessment related to fire was not in place on the day of inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Daily COVID-19 cleaning checklists had not been completed since 17 July 2022 while there was inconsistencies in the checklists that were completed before then. Another cleaning schedule used in this centre was for a different house in a different centre. Some taps in the current centre were seen to require further cleaning. The toilet seat in a bathroom used by one resident, who had been absent from this centre since the previous week, was visibly unclean.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety systems were provided for in the centre which included a fire alarm, emergency lighting, firefighting equipment and fire doors. One fire door was observed to be wedged open during the initial stages of the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plan of one newly admitted resident was not completed while another resident's personal plan contained limited guidance on specific interventions to support some of the resident's assessed needs. Comprehensive assessments of needs were not being conducted in a manner consistent with the regulations.

Judgment: Not compliant

Regulation 8: Protection

Staff working in the centre had undergone safeguarding training and no safeguarding concerns were identified during this inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were seen to be treated respectfully during this inspection while resident meetings were happening on a regular basis where matters such as activities and fire safety were discussed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Goldfinch 6 OSV-0008268

Inspection ID: MON-0037235

Date of inspection: 27/07/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: On the day of inspection the inpector was happy that Rosters were maintained for the centre but the staffing had increased for the residents currently living in this centre. However, given the changing needs of one resident, night-time staffing arrangements required review. • MDT scheduled 31/08/22 to assess changing needs of one resident and review staffing levels regarding waking night staff. Risk assessment has been completed to monitor the risk of waking night cover . A discussion took place on 31/8/2022 with MDT and the following outcome measure are in place to monitor same the risk assessment. 1. MDT took place on 31st August 2022. 2. MDT are of the view that there is insufficient evidence to support the requirement for waking staff at this time. Recommendation has been agreed that sleep chart will be implemented and the situation will be kept under review. 3. A full review will be carried out by CNS in ageing for a full health needs assessment on the resident. A referral will be made to AMT if indicated by this health needs assessment. 4. Follow up MDT review will be scheduled in 2 months. • Business case submitted to HSE December 2021 concerning funding for one to one support in Day Service. This is discussed at monthly HSE business cases meetings with the HSE, next meeting 13/09/22. • Additional support staff in place following approval of a business by the HSE in July 2022.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: 5. The Directory of Residents has been updated to reflect new admission to our designated centre.	
Regulation 23: Governance and	Substantially Compliant

management	
Outline how you are going to come into compliance with Regulation 23: Governance and management: • We will develop a check list, from the experience with this registration inspection, to ensure that learning is shared for all future new registrations and the same issues do not arise. • We will ensure that internal 6 monthly unannounced inspections is carried out within 6 months once a Designated centre is open as per practice todate	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • The Statement of purpose has been updated and reflects an accurate description of a small garden in the designated centre.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • Personal assets register completed and is recorded in the resident's financial folder. Completed 28/7/2022	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Toilet seats replaced in all bathrooms 28/07/ 2022 • Administrator requested maintenance upgrade. The plaster on the external window sill to be repaired and will be completed by 31/8/2022	
Regulation 20: Information for residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 20: Information for residents: • The Residents guide has been updated to reflect accurate description of a small garden.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Administrator discussed with staff the importance of recording AIRS for night waking and staff will record previous incidents on AIRS to reflect same. Complete 18/08/22. • Risk Assessment completed to establish risk to resident in regards to night waking. Complete 18/08/22. . Outcome from the MDT meeting is as followings to monitr the risk going forward around waking night cover :	

1. MDT took place on 31st August 2022.
2. MDT are of the view that there is insufficient evidence to support the requirement for waking staff at this time. Recommendation has been agreed that sleep chart will be implemented and the situation will be kept under review.
3. A full review will be carried out by CNS in ageing for a full health needs assessment on the resident. A referral will be made to AMT if indicated by this health needs assessment.
4. Follow up MDT review will be scheduled in 2 months.
5. Fire safety risk assessment has been completed for the DC on 28/7/2022

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The Administrator provides management and oversight to the designated Centre. This includes monthly staff meetings, completion of monthly Quality Improvement tool, and fortnightly review of IPC practices with the Centre, quarterly staff supervision, weekly team meetings with area manager, and monthly meetings with Director of Services. Any changes to the IPC measures will be discussed and forwarded to the relevant PIC/Adminstrator when required. PIC and Area Manager will ensure to complete unannounced visits to the Center in order to monitor record keeping and ensure all IPC measures are in place and completed appropriately.
• Administrator to ensure cleaning check lists are completed and will spot check regularly in each house of the Designated Center in relation to adherence to standards as required.
• Person in Charge & Administrator to meet with staff to discuss the importance of IPC and how they will ensure all IPC are met while on duty i.e. cleaning checks completed, appropriate storage of mops and buckets continue to have house meetings and have IPC as an agenda item and continue to discuss with staff and monitor any issues in the Center.
• Any maintenance issues identified as part of the inspection were followed up and completed by Administrator

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Person in Charge will ensure that the risk management policy, will include hazard identification and assessment of risks throughout the designated Centre and the measures and actions in place to control the risks identified and the measures and actions in place to control the following Fire Safety risks
• Person in Charge has updated risk folder to ensure Fire Safety Risks are in place Person in Charge to include in monthly agenda the discussion of the proper use of fire doors and inform all staff not use any wedges on doors to keep them open.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• The term AON (assessment of need) or DSA (Disabilty support assessment) are terms used by the Services when a full assessment is carried out on admission of a person to the services. Once a person is admitted to the Services there is ongoing review of the needs of each individual as reflected in our Person Centred Planning process and MDT review process. This process of review ensures the services operates in line with the regulations.
• We will ensure that a person centred plan is completed for all new residents within 28 days of admission to our Services.
• We will review each PCP to ensure there is sufficient guidance on specific interventions to support the residents assessed need.
• Our PCP Process includes a Best Possible health outcome and goals can be identified for this outcome. As agreed at MDT on 31st August a full review will be carried out by CNS in ageing for a full health needs assessment of one residents whose needs are changing. A referral will be made to AMT if indicated by this health needs assessment. Also the clinical psychologist will carry out a review of one resident's Dementia screening assessment. This will be completed by 30st September 2022.
• All new admissions going forward will ensure to have a PCP in place within 28 days. A keyworker has been assigned to the new resident and his keyworker and the administrator are engaging in the PCP process and will have fully completed PCP by 30th September 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 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.	Substantially Compliant	Yellow	01/08/2022
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.	Substantially Compliant	Yellow	15/08/2022
Regulation 17(1)(b)	The registered provider shall	Substantially Compliant	Yellow	19/08/2022

	ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	19/08/2022
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	15/08/2022
Regulation 20(2)(a)	The guide prepared under paragraph (1) shall include a summary of the services and facilities provided.	Substantially Compliant	Yellow	15/08/2022
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	15/08/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	18/08/2022

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	31/08/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/08/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	15/08/2022
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health,	Not Compliant	Orange	31/10/2022

	personal and social care needs of each resident is carried out prior to admission to the designated centre.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/10/2022
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	28/08/2022
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	Not Compliant	Orange	18/08/2022

	circumstances, which review shall assess the effectiveness of the plan.			
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 frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	18/08/2022