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:	Seacrest Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	29 November 2022
Centre ID:	OSV-0001509
Fieldwork ID:	MON-0037856

About the designated centre

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

Seacrest Services supports up to seven male and female adults with a diagnosis of intellectual disability, who require a level of support ranging from minimum to high, and which may include co-morbidity. This service is a combination of residential and respite care. Respite care is provided on the basis of planned, recurrent, short stay placements. Seacrest is a two-storey house in an urban residential area. The house is centrally located and is close to amenities such as shops, restaurants, public transport, pharmacist and a church. All residents in the centre have their own bedrooms. The physical design of the building renders parts of it unsuitable for use by individuals with complex mobility needs or wheelchair users, although some residents with physical disabilities can be accommodated on the ground floor. Residents are supported by a staff team that includes the person in charge, social care workers and care assistants. Staff are based in the centre whenever residents are present, including at night time.

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
Tuesday 29 November 2022	09:30hrs to 17:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations and to follow up on non-compliance's identified at the previous inspection.

On arrival at the centre, staff on duty guided the inspector through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene and face covering.

The centre comprises a large detached house, accommodating up to seven residents. The house is located in a quiet residential area of the city suburbs and close to a range of facilities, amenities and shops. On the day of inspection, there were four residents living in the centre and one resident who normally availed of the service at the weekends was at home with their family at the time.

The inspector met with five staff working in the centre, the person in charge and assistant director of client services. The inspector also met with all four residents living in the centre and observed them in their home including care and support interactions between staff and residents. Some residents were unable to tell the inspector their views of the service but appeared in good form, content and comfortable in the company of staff. Staff were observed to know the residents well as they chatted and interacted with residents in a friendly, caring and respectful manner. Residents had complex health care needs, three residents were wheelchair users, some residents were assessed as requiring two staff for transfers using a hoist and some residents required a high level of supervision to ensure their safety. Residents had a range of social care needs and were provided with an individualised day service programme from their house.

On the day of inspection, there were a combination of residential and day service staff on duty to support and meet the needs of residents. Staff informed the inspector that staffing levels in the centre had improved over the past number of months and there were now always a minimum of three staff on duty during the day and evening time. Staff advised that the improved staffing ratios had a positive impact upon residents lives resulting in staff having more time to spend with residents on a one to one basis, and being able to facilitate and support greater resident choice for outings and activities.

On the morning of the inspection, some residents were having their breakfast, some were relaxing in the sitting room and another was still in their bedroom being assisted with personal care. Three residents were getting ready to leave the centre to attend a weekly music session. A resident told the inspector how they were looking forward to attending the music session which was held weekly in the local day service building. They mentioned how they enjoyed meeting up with friends and dancing to the music. The resident and staff spoke of enjoying a trip the day previous to the Christmas markets and having tea and scones in a city centre hotel.

Residents also enjoyed a range of activities including weekly reflexology and massage therapy sessions in house. They spoke about getting out for daily walks, visiting the local hairdressers, getting their nails painted and visiting the shops. One resident told the inspector how they enjoyed visiting the local church, going to mass or going to light a candle. They mentioned that the church was located close by and that they could walk if they wished. Residents enjoyed going out for lunch on some days and getting a takeaway meal at weekends. A resident told the inspector how they also enjoyed going out for an occasional drink.

During the early afternoon, residents returned to the house to have their lunch. Staff were observed supporting residents to have their preferred choice of meal. Residents who required modified diets were supported in line with the recommendations of the speech and language therapist (SALT). During the afternoon, some residents relaxed in the house, one resident attended the local barber for a hair cut, another used a motor therapy cycling device in line with their physiotherapy programme, others spent time completing table top activities and reviewing magazines.

The house was found to be spacious and comfortably furnished in a homely style. Each resident had their own bedroom. Bedrooms were spacious, had a wash hand basin, television and adequate storage space for personal items. All bedrooms were personalised with residents' own effects, family photographs and other items of significance to them. There was an adequate number of toilets and showers located on each floor. There was a variety of communal day spaces provided including a large sitting room, kitchen with dining area and activity room. There were framed photographs of residents enjoying a variety of activities displayed throughout the communal areas of the house. There was a laundry room which included storage for cleaning equipment, a staff office and staff sleepover bedroom provided. Residents had access to a large landscaped garden and patio area at the rear of the house. The ground floor of the house and the external garden areas were accessible for wheelchair users with suitable ramps and handrails provided. While the house was generally found to be well maintained in a visibly clean condition internally, the external grounds of the house required cleaning and maintenance. Painting was also required to some internal walls and some flooring required repair. The person in charge outlined that repair and maintenance works had been identified, and that the ancillary manager was due to visit the centre to schedule these works. There was adequate aids and specialised equipment provided to meet the needs of residents and systems were in place to ensure that they were regularly serviced. However, the storage for equipment required review. There was no separate storage area provided resulting in large items of specialised equipment being stored in communal areas of the house, front hallway and unused bedroom.

Residents were consulted with on an ongoing daily basis and the inspector observed staff offering choice throughout the day. Monthly meetings with residents continued to take place. The minutes of the most recent meeting 25 November 2022 showed that topics such as safeguarding, COVID-19, meal choices, activities, fire safety, personal goals, advocacy and rights were discussed.

The next two sections of the report outline 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 residents lives.

Capacity and capability

This unannounced inspection was carried out to

- monitor compliance with the Regulations
- follow up on non-compliance's identified at the previous inspection
- following notification to a change in the person participating in the management of the centre
- following a recent notification of a change to the person in charge of the centre.

The findings from this inspection showed that deficits in governance and management previously identified were in the process of being addressed, non compliance's identified during the last inspection particularly in relation to staffing had been addressed and other non compliance's were partially addressed. However, the provider had not fully implemented its own compliance plan which was submitted to the Chief Inspector following the last inspection. Further improvements were required in relation to, records that were required to be maintained, review of restrictive practices, on-call arrangements, the premises, risk and wound management.

Following the last inspection there had been further changes to the management arrangements in the centre. The person in charge at the time of the last inspection had vacated the post on 9 September 2022. A notification of a change to the person in charge was received by the Chief Inspector of Social Services on 15 September 2022, however, this person did not take up the post. In effect there had been no person in charge of the centre as required by the regulations since 9 September 2022. The Chief Inspector received a further notification of a new person in charge on the 16 November 2022. This person is also the person in charge for two other centres and proposes to allocate 12 hours per week to each centre. The hours allocated to the person in charge to ensure effective governance and operational management of this centre was contrary to the providers commitment (24 hours per week) as outlined in the compliance plan response to the previous inspection report. The person in charge is supported by the assistant director of client services who was appointed to the post in recent months. The inspector met with both the person in charge and the assistant director of client services. They outlined the current challenges in recruiting suitable persons for the post of person in charge and advised that it was planned to appoint a team leader to further support the person in charge in their role. They advised that interviews for the post of team leader were taking place on the day of inspection. The successful candidate was expected to commence in the role in approximately two weeks with 18 hours being allocated to administrative and operational management duties. They both showed a positive

attitude, a willingness to comply with the regulations, spoke of their commitment and outlined their management strategies to ensuring effective oversight of the service.

The on-call management arrangements for out-of-hours during the weekdays still required review. While there were informal arrangements in place whereby the assistant director of services was on-call, they advised that it would take approximately one hour to reach the centre which would be inadequate in the event of an emergency.

On the day of inspection, there were sufficient staff on duty to support the residents assessed needs in line with the statement of purpose. There were five staff on duty during the day, two staff from the residential service, one who was completing induction training and three staff from the day services. The assistant director of client services confirmed that two new staff had been recruited and commenced in their roles and recruitment was taking place for another staff member who had recently left their post but had remained available as a relief staff member pending filling of the post. Staff spoken with confirmed that there was always a minimum of three staff on duty during the day and evening time with one staff member on duty at night time. Staff advised that they were satisfied with the current staffing arrangements and outlined how the quality and safety of care for residents had improved as a result. They mentioned how they could now provide more person centered care as opposed to task focused care and were able to support residents make daily choices regarding their preferred activities and outings. While staffing records were not available to review in the centre, staff spoken with confirmed that they had completed all mandatory training.

While improvements were noted to some records required to be maintained by the regulations, further improvements were required. A review of a sample of residents files showed that they had been reviewed and updated to reflect the current needs of residents. However, some records as required were still not available in the centre, for example, there were no staff training records available, a written review on the quality and safety of care in the centre completed in August 2022 was also not available. Records were found to be stored securely in the locked staff office, however, the office filing system required review to ensure that records were available and readily accessible. Boxes of files for archiving were removed from the office during the inspection to be stored in the archiving depot off site. The person in charge spoke of their plans to reorganise and upgrade the existing filing system to ensure that records were clear, up-to-date and readily accessible.

The person in charge showed the inspector templates for a monthly audit schedule which they planned to implement in order to assist them in maintaining oversight of the quality and safety of care in the centre. Monthly audits were planned in areas such as fire safety management, medication management, infection, prevention and control, restrictive practice and residents files. They also planned to review incidents on a monthly basis. The person in charge and assistant director of client services advised that they planned to meet on a weekly basis and meet with staff on a monthly basis to discuss the results of audits, share learning and ensure that any improvements identified were addressed. The person in charge had completed an

environmental audit. Areas identified that needed to be addressed had been brought to the attention of the ancillaries manager who was due to visit the centre and schedule improvements and maintenance works. The assistant director of client services advised that a full review of the current service was being undertaken with a view to ensuring that the service being provided was in the best interest of residents in terms of individual choice and in accessing the community.

Regulation 14: Persons in charge

A new person in charge was recently appointed. The person in charge had the required qualifications and experience for the role. They were knowledgeable regarding the regulations and their statutory role. The person in charge is also in charge of two other designated centres and outlined clearly how they planned to ensure the effective governance, operational management and administration of the centre.

Judgment: Compliant

Regulation 15: Staffing

There was an adequate number of staff on duty on the day of inspection to meet the needs of residents. Additional staff had been recruited since the previous inspection. Staff spoken with confirmed that there was always a minimum of three staff on duty during the day and evening time with one staff member on duty at night time. Interviews to appoint a team leader were taking place on the day of inspection.

Judgment: Compliant

Regulation 21: Records

Records as required by the regulations were still not available in the centre, for example, there were no staff training records available, a written review on the quality and safety of care in the centre completed in August 2022 was also not available. The office filing system required review to ensure that records were available and readily accessible.

Judgment: Not compliant

Regulation 23: Governance and management

While there had been changes to the management arrangements in the centre, these arrangements and systems had only been recently introduced, were not yet fully operational and therefore, the inspector could not yet evidence their effectiveness.

There was still no formal on-call arrangements during the weekdays. While there were informal arrangements in place whereby the assistant director of services was on-call, they advised that it would take approximately one hour to reach the centre which would be inadequate in the event of an emergency.

The provider had not fully implemented its own compliance plan which was submitted to the Chief Inspector following the last inspection. Records as required by the regulations were still not available. There were no staff training records available in the centre, therefore, the inspector could not evidence that all staff had completed mandatory training or other training that the provider had indicated would be completed as part of their compliance plan. The provider had indicated that an unannounced audit had been completed on the 5 August 2022, however, it was not available for review in the centre. There had been no independent review of restrictive practices completed as outlined in the providers own compliance plan response to the previous inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to reflect the changes and current management arrangements in the centre.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that the residents received a good quality and person-centred service where their rights and individuality were respected. The residents spoken with stated that they liked living in the centre, appeared to be content and relaxed in their environment and with staff supporting them. Staff knew the

residents well, were familiar with and knowledgeable regarding their up-to-date assessed health and social care needs and the individual recommendations of allied health professionals. Residents had lived together for a long number of years and got on well with one another. Improvements to staffing arrangements and general oversight of the service had ensured that residents were being offered an improved quality and safer service.

Residents had access to general practitioners (GPs), out of hours GP service and a range of health and social care professional services. A review of a sample of residents files indicated that residents had been regularly reviewed by their GP and a range of healthcare professionals including the physiotherapist, speech and language therapist (SALT), occupational therapist (OT), psychologist, chiropodist and dentist. Residents had also been supported to avail of vaccination programmes. Files reviewed showed that residents had an annual medical review. Each resident had an up-to-date hospital passport which included important and useful information specific to each resident in the event of the required admission to hospital.

The inspector reviewed a sample of residents files including the files of residents with complex healthcare needs. There was evidence that residents' health, personal and social care needs had been recently assessed and care plans were found to be place for all identified issues. A range of up-to-date risk assessments were completed for residents including risk of developing pressure ulcers, falls risk, swallow assessment, moving and handling, continence and restrictive measures in use. Care plans were found to be recently reviewed, informative, individualised and person centered. Residents who required supports with communication had comprehensive plans in place which were tailored to their individual communication preferences and support needs.

Residents' nutritional needs, were assessed, their weights were monitored regularly and plans of care had been developed as required based on these assessments and monitoring outcomes. The recommendations of the speech and language therapist (SALT) provided detailed feeding, eating and drinking guidelines for residents who required a modified consistency diet. Staff were knowledgeable regarding this guidance and were observed implementing it in practice.

Residents assessed as being at high risk of falls were being supervised closely by staff. An environmental safety checklist had been completed as part of the falls prevention strategy. The physiotherapist had assessed residents and they had individual physiotherapy programmes in place. Residents who required specialised foot wear had been assessed and appropriate footwear provided. The inspector observed some residents partaking in their physiotherapy programme and noted that residents at high risk of falls were supervised by staff throughout the day.

The inspector saw that the risk of developing pressure ulcers was assessed regularly and appropriate preventative interventions including pressure relieving equipment was in use. There was a comprehensive skin integrity care plan in place which outlined clear guidance for staff as well as guidance from the occupational therapist (OT) on the correct use of pressure relieving equipment. Staff had support form a nurse who worked in the organisation who visited to review and complete wound

dressings as required. Staff described a stage 1 pressure wound and records reviewed showed that the nurse was currently visiting and dressing the wound. However, there was no wound chart or wound assessment in place and therefore, it was difficult to assess the progress of the wound.

While improvements were noted to the management of restrictive procedures in use, an independent review of all restrictive procedures had not been completed as outlined in the providers compliance plan response to the previous inspection findings. There were some restrictive procedures in use including the use of a best vest, lap belts and bed rails for some residents. The inspector noted that risk assessments for their use had been recently updated and there was evidence of multidisciplinary input into the decision taken to use them. There were clear rationales for their use outlined, including other alternatives that were tried or considered. Logs were being completed indicating the duration of each use and safety checks at night time were being recorded for the use of all bed rails. While there were no staff training records available, staff spoken with confirmed that they had received training on residents rights and and use of restrictive practices. The person in charge advised that they will be completing a monthly review of all restrictive practices in use to ensure that the least restrictive practice is being used for the shortest time possible. Following the last inspection, the lap belts were removed from a comfort chair used occasionally by some residents and therefore, they were no longer in use.

Staff spoken with confirmed that they had completed specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm. The support of a designated safeguarding officer was available if required. The Chief Inspector of social services had been notified in recent months of some incidents relating to safeguarding issues. The management team advised they were being managed in line with the safeguarding policy, that investigations were still in progress and they undertook to submit updates regarding the progress of the investigations.

The house was spacious, comfortable and decorated in a homely manner. The kitchen and main living room had been recently refurbished and redecorated. All residents had their own bedrooms. The ground floor area was suitable for residents using wheelchairs and other specialised equipment.

The house was generally found to be well maintained in a visibly clean condition internally, however, improvements were required to some wall and floor surfaces and the external grounds of the house required cleaning and maintenance. There was an accumulation of dead leaves, debris, branches and moss on the external grounds and front driveway which posed a risk to residents. The person in charge had identified these issues and reported that the ancillary manager was due to visit the centre to schedule these works. There was adequate aids and specialised equipment provided to meet the needs of residents. Staff spoke of on-going assessment of residents by the OT to ensure that the most appropriate equipment was provided to meet the individual needs of residents. There were systems in place

to ensure that equipment including the hoists were regularly serviced. However, the storage for equipment required review. There was no separate storage area provided resulting in large items of specialised equipment being stored in communal areas of the house, front hallway and unused bedroom.

The inspector reviewed the risk register which had been recently updated in August 2022. Some issues identified during the last inspection had been addressed. Staffing and the changing needs of residents were now included in the register. The person in charge outlined that she planned to complete a comprehensive review of all risks and control measures in place as well as reviewing risk on an ongoing basis and including it as an agenda item for all staff meetings. However, the provider had still not put in place a robust system for responding to emergencies at night time when there was only one staff on duty as evidenced by a resident having to get an ambulance to hospital alone as there were no staff available to attend with them.

Regulation 17: Premises

Improvements were required to some wall and floor surfaces and the external grounds of the house required cleaning and maintenance. There was an accumulation of dead leaves, debris, branches and moss on the external grounds and front driveway which posed a risk to residents. The storage for equipment required review. There was no separate storage area provided resulting in large items of specialised equipment being stored in communal areas of the house, front hallway and unused bedroom.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had still not put in place a robust system for responding to emergencies at night time when there was only one staff on duty as evidenced by a resident having to get an ambulance to hospital alone when there were no staff available to attend with them.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Some improvements were required to wound management. Staff reported and records reviewed showed that a nurse was currently visiting and dressing a stage 1 pressure ulcer. There was evidence of an up-to-date risk assessment and care plans

in place as well as regular review by a nurse in the organisation. however, there was no wound chart or wound assessment in place and therefore, it was difficult to assess the progress of the wound.

Judgment: Substantially compliant

Regulation 6: Health care

Staff continued to ensure that residents had access to the healthcare that they needed. Residents had regular and timely access to GPs and health and social care professionals. A review of residents files showed that residents had been referred and recently assessed by a range of health and social care professionals. Residents were supported to avail of vaccine programmes.

Judgment: Compliant

Regulation 7: Positive behavioural support

While improvements were noted to the management of restrictive procedures in place, an independent review of all restrictive procedures had not been completed as outlined in the providers compliance plan response to the previous inspection findings.

Judgment: Substantially compliant

Regulation 8: Protection

There were no staff training records available to review in the centre, therefore, the inspector could not evidence that all staff had completed training in relation to safeguarding residents, and the prevention, detection and response to abuse. The Chief Inspector of social services had been notified in recent months of some incidents relating to safeguarding issues. The management team advised they were being managed in line with the safeguarding policy, that investigations were still in progress and they undertook to submit updates regarding the progress of the investigations.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The privacy and dignity of residents was well respected by staff, all residents had a detailed intimate care plan in place. Residents had access to advocacy services. Staff were observed to interact with residents in a caring and respectful manner. The residents had access to televisions, magazines and information in a suitable accessible format. Residents continued to be consulted with on a daily basis and at regular house meetings. Topics recently discussed included safeguarding, COVID-19, meal choices, activities, fire safety, personal goals, advocacy and rights. Residents were supported to practice their religious rights, residents reported going to mass and visiting the local church. Improvements to staffing arrangements in recent months allowed residents greater choice in attending activities and going places of interest to them.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Seacrest Services OSV-0001509

Inspection ID: MON-0037856

Date of inspection: 29/11/2022

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Staff training records have been reviewed, updated and are easily accessible stored in the office, completed 30/11/2022. The office filing system has been reviewed by PIC and a new user friendly filing system is now in place. Records are now clear, up-to-date and readily accessible, completed 06/12/2022. All archiving has been removed and stored in an appropriate archiving depot, this is stored in the Ability West training depot and was transferred on the 06/12/2022.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Both a PIC and Team Lead have been allocated to the service. The PIC has been allocated 12 hours weekly office administration and the Team Lead has been allocated 18 hours office administration weekly, commenced 05/12/2022. In relation to the announced Provider Led audit which was completed on the 05/08/2022, this was located and refiled in the office 30/11/2022. A further Provider Led Audit was completed on 11/11/2022, and report is accessible in the office. The current on call system which is included in procedures is that Assistant Directors of	

Client Services are on call for out of hours Monday to Friday for their respective services and on call rota is in place for weekends. Once the current recruitment process within Client services is complete a review of the on call system completed

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 to reflect the current changes that have taken place. PIC allocated 12 hours office based and Team Lead allocated 18 hours office based weekly 05/12/2022. This was submitted to HIQA on the 21/12/2022.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Improvements to the external grounds of the house have been completed where a gathering of dead leaves, debris, branches and moss have been removed to reduce the risk posed to residents 08/12/2022. PIC will continue to link in with Domiciliary Manager to ensure the upkeep of the premises.

Further internal works (storage) will be carried out to accommodate large items of specialised equipment. A plan has been drawn up and a timeline of early 2023 given for works to be completed. This is overseen by PIC and Team Lead.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Seacrest has teamed up with another service in the local area (approx. 6 minutes from the centre). This service has a sleepover and will provide support to the Seacrest staff at night time should this be required. Agreed by 6/12/2022. Contingency plan in the centre has been amended to include this.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A wound chart will be implemented and documented to assess and progress of any wound. PIC will have a booklet on pressure sores and this will be available on site for all staff, also a nurse will visit service and discuss pressure sores at a team meeting. All staff will contact the GP or Care Doc for advice if required to provide and support and a protocol will be written up to provide guidance for staff.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A review of restrictive practice has taken place by PIC and Team lead 13/12/2022. Full review completed. PPIM to complete an environmental assessment 31/01/2023.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Staff training has been reviewed and updated. A staff training folder can be located in the office and is easily accessible to staff. The training records are updated as training is completed or the addition of new staff into the service.

All incidents will be reviewed by PIC, TL and staff at the monthly team meeting and learning will be discussed. A review of incidents will be completed monthly and discussed at the staff team meeting. Each key-worker will provide an update on each Service Users.

All staff have completed Safeguarding training and this is documented in the staff training records. Additional Safeguarding training will be completed with all staff in-house by 31.01.2023.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2023
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	06/12/2022
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'	Not Compliant	Orange	05/12/2022

	needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	06/12/2022
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	23/12/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/12/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical,	Substantially Compliant	Yellow	31/01/2023

	chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	31/01/2023