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:	Steadfast House Residential Service - Group Home
Name of provider:	Steadfast House Company Limited By Guarantee
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	23 August 2022
Centre ID:	OSV-0001631
Fieldwork ID:	MON-0036633

About the designated centre

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

Steadfast house residential service provides care and support to five female residents on a full time basis. Residents are supported on a individual basis in line with their assessed needs, wishes and preferences. The centre has a staff team consisting of a person in charge, a social care worker, and healthcare assistants. The person in charge is supported in their role by the chief executive officer.
The centre is located within walking distance of a town, and residents can access a range of amenities and activities in the local community. Residents are supported by one to two staff during the day and one staff overnight. Four residents attend day services every day, and one resident is supported with activities in the centre and in the community, as is their preference. The premises is laid out to meet the individual and collective needs of residents in a homely environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 23 August 2022	10:00hrs to 18:40hrs	Caroline Meehan	Lead

What residents told us and what inspectors observed

This was a follow up inspection, the purpose of which was to ascertain if the provider had implemented and sustained the improvements, which had been outlined in the last inspection in January 2022. In November 2021, an unannounced inspection of this centre, had highlighted significant concerns with the governance and management of this centre, and the impact poor oversight arrangements were having on the care and support provided to residents. The provider subsequently attended a warning meeting and was required to respond to a warning letter. A subsequent inspection in January 2022 demonstrated that improvements had been made in the centre, and the provider was in the process of developing a number of improved oversight arrangements, so as to assure themselves that the standards of care and support provided to residents was in line with regulatory requirements.

This inspection found the provider had not sustained these improvements, and seven of the nine regulations inspected were found to be not compliant. Significant concerns relating to the oversight of the centre were identified on this inspection, and a number of governance arrangements which had been outlined at the previous inspection and subsequent compliance plan were not implemented. This meant that the assurances the provider had given to the Health Information and Quality Authority (HIQA) were not followed through on. As a result the safety and wellbeing of residents was being put at risk.

At the last inspection, the provider had outlined the overall responsibility of risks would be at board of management level, however, the proposed oversight arrangements were not implemented. The person in charge and the chief executive officer had not been provided with the appropriate resources to respond to risks and to implement the required changes in the centre. There was a lack of effective reporting mechanisms to and from the board of management, and it was not evident who had the authority to make decisions in the centre.

There were a number of risks identified on the day of inspection including inadequate staffing and behavioural support resources, and safeguarding risks. This meant that residents were not being provided with the appropriate resources, to ensure they were protected, and to ensure their emotional wellbeng was supported. The person in charge had not been supported with adequate time to fulfil their responsibilities, and as a consequence the additional support staff needed to develop and maintain personal plans, assessments of needs, and risks assessments was not being provided.

The inspector spoke to two of the residents, and briefly met three other residents when they returned from day services. While some residents appeared happy in the centre, the impact of a decision made by the provider, was observed to be negatively affecting some residents' welfare and wellbeing.

Overall residents were provided with meaningful activities both in the centre and in

the community, and were supported to maintain relationships with their families, friends and significant others. Staff were observed to be kind and respectful in their interactions with residents, helping them with their personal care needs, and facilitating the choices of residents.

Residents were supported to maintain family and personal relationships. On the day of the inspection, one of the residents was visiting their family during the evening, another resident had recently returned from a break at home, and another resident was supported to attend a significant family occasion recently. There were ample room in the centre to facilitate the interests of residents, including an outside cabin where residents enjoyed craft activities and listening to music.

The inspector observed that while there were some good practices within the service, the governance and management arrangements in place were not adequate, which was having a negative impact on the quality and safety of the service being delivered. These matters will be discussed further in the next two sections of this report.

Capacity and capability

The inspector found there were poor governance and management arrangements in the centre, and the provider did not have systems in place to assure themselves that the care and support in the centre was safely meeting the needs of the residents. The provider had not sustained the improvements that had been found at the last inspection, in response to a warning meeting and a warning letter, and the inspector had concerns about the fitness of this provider in terms of providing a safe quality service.

The provider had not ensured there were adequate staffing levels in the centre, in particular at night time, and was required to provide assurances by the end of the inspection. Similarly the provider had not responded appropriately to the changing presentation of a resident, and had not ensured that staffing levels were in line with stated requirements.

The provider had not resourced the centre appropriately so as to ensure the specific and emerging needs of residents were safely and effectively met. Specifically staffing levels and the provision of behavioural support were not adequate in the centre, and were putting residents at risk.

While there was a management structure in place, the reporting mechanisms to and from the board of management required significant improvements. The assurances which had been provided to HIQA during the last inspection, and subsequent compliance plan, relating to improved reporting and assurances mechanisms to the board of management were not in place on the day of inspection. Lines of accountability and responsibility were not clear specifically relating to resourcing the

centre, responding to risks in the centre, and completing actions identified in audits.

There was inadequate monitoring of the centre, and the unannounced visit by a person nominated by the provider, did not highlight ongoing issues which were found on this inspection, and did not adequately report on the quality and safety of care and support. The response to actions identified during the unannounced visit had not been adequately responded to by the provider to date.

The arrangement for the person in charge to manage this and one other designated centre was not ensuring the effective governance and management of the centre, and was impacting the care and support being provided to residents.

Regulation 14: Persons in charge

The inspector was not assured that the arrangement for the person in charge to manage two designated centres was ensuring the effective governance, operational management, and administration of the designated centre.

The person in charge was appointed in April 2022 and was employed in a fulltime capacity. The person in charge had the required knowledge and experience to fulfil their role. The person in charge was also responsible for another designated centre, and they attended both centres daily. The inspector found that that some issues identified in the centre were not being addressed in a timely manner, such as therapeutic support for residents, and the inspector found the remit of the person in charge, in managing the two designated centres was impacting on their ability to attend to their responsibilities in this centre, in line with regulatory requirements.

In addition, from a review of residents' personal plans, risk assessments, a safeguarding plan, healthcare appointments, and the actions from the unannounced visit, it was clear there was significant amount of issues which required to be addressed by the person in charge. The provider had identified that the person in charge required additional support with this, both in terms of the skills and time required to complete these tasks. A staff member had also told the inspector, staff needed more support in terms of clinical input to complete and review, for example, personal plans and risk assessments.

Judgment: Not compliant

Regulation 15: Staffing

There were insufficient staff numbers in the centre in order to ensure residents were supervised appropriately and supported adequately in line with recommendations.

The staff team consisted of healthcare assistants. There was one staff on duty in a

sleepover capacity at night-time. The person in charge told the inspector that staff had raised concerns about these arrangements and were frequently up at night time attending to some residents' needs.

The inspector reviewed a sample of care notes, and sleep charts for 3 residents over the preceding four months, and found these were reflective of staff concerns. For example, one resident required support on five nights over a nine day period, and another resident on four of an eleven night period. Similar trends were noted on two other months records reviewed for one of these residents. The person in charge told the inspector this was under review, and sleep records were being maintained. In light of a known safeguarding risk and the ongoing needs of residents at night-time, the inspector found the provider had not responded effectively or efficiently to this staffing issue. Under this regulation the provider was required to address this immediate risk that was identified on the day on the inspection. The manner in which the provider responded to the risk did provide assurance that the risk was adequately addressed, and arrangements had been made to provide a waking staff from 21.00hrs to 09.15 hrs nightly.

During the day there were 2 staff on duty in the morning until 10.00hrs, one staff until 15.00, and two staff on duty until 20.30 hrs. From a review of residents' plans and their required supervision levels, the inspector found adequate staffing levels were not in line with stated requirements. In particular staffing levels had not been adequately reviewed or responded to in light of a residents' changing presentation. The inspector acknowledges that the person in charge had made some changes to the roster in the past few days to ensure a third staff was on duty in the morning between 8.00 and 9.00hrs.

Planned and actual rosters were maintained in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not resourced the centre to ensure the needs of the residents could be effectively met. While there was a management structure in place, the lines of accountability and responsibility were not clear, in particular at board of management level. The service was not monitored effectively to ensure risks were identified and responded to appropriately.

Sufficient resources had not been deployed to the centre including staffing, and behavioural support, in line with the stated needs of residents. From speaking with the chief executive officer, it was unclear how resources were planned or managed. For example, the chief executive was unable to verify the arrangement for a budget for staffing in the centre, and this was compounded by a lack of clear reporting and feedback structures from the board of management.

The chief executive officer (CEO) had commenced their post in March 2022 and was

nominated as a person participating in management. The CEO reported to the board of management, and submitted a quarterly report to the board, along with attending a quarterly board meeting. The CEO outlined that the arrangement reported at the last inspection, for the person in charge to submit a monthly report to the board had not been in use since they had commenced their post. Similarly the person in charge was unaware of this arrangement. The chief executive had last attended a board meeting and submitted a report in May 2022. However, given the issues that had emerged in the preceding months, for example, safeguarding and staffing issues, it was evident that in the absence of authority for the CEO to respond to these risks, in terms of resourcing, that the board of management were not managing and mitigating these risks effectively.

In the interim months between board meetings with the chief executive, clear lines of reporting had not been established in order to deal with emerging risks. For example, at the last inspection the provider had outlined their intention to establish a quality and risk subcommittee at board level, the purpose of which was to provide assurances to the board of management, that risks were being managed, and that incidents were being responded to appropriately. The CEO told the inspector they were unaware of this committee, and during the feedback meeting a board member stated this committee had not been established due to recruitment issues.

The provider had not monitored the centre appropriately, and had not implemented the measures outlined in their compliance plan from the previous inspection relating to verifications to the board of management. For example, in the previous compliance plan the provider had outlined they would develop an external audit protocol with the funder, and finalise terms of reference for quarterly external audits by the funder, who would then report back to the board of management. The board member confirmed that this had not been discussed with the funder at their scheduled meeting in March 2022, and therefore a schedule of external audits were not implemented as planned.

An unannounced visit had been carried out in July 2022 by a person who had previously been employed in the service. However, a number of issues identified during this inspection were not identified during this review. There were 29 actions developed following the review; however, the details of a significant number of issues to be actioned, were not contained in the report of the visit. Some actions had been completed by the CEO and the person in charge, and some of the remaining actions had an upcoming date for completion.

However, an action related to updating residents' personal plans, including for example, risk assessments, goals, and medicine kardexes, had a lengthy timeframe for completion, and did not provide assurances that up-to-date information and guidance on residents' needs would be in place for staff. This was compounded by the need to seek assistance from a nurse external to the centre, and by the scope of the person in charge, which was discussed in Regulation 14. The review had also identified the need for the actions from the previous inspection to be completed; however, as noted these were not wholly complete on the day of inspection.

Judgment: Not compliant

Quality and safety

The inspector found residents were not being provided with the appropriate care and support, which impacted their wellbeing and welfare. A resident had been exposed to a known risk, which had had a negative impact on their emotional wellbeng and safety. Therapeutic supports had not been consistently provided, in order to ensure residents' behavioural support needs were reviewed, and the emotional needs of residents were met. The oversight of restrictive practices, assessments of need, personal planning and risk management required significant improvement.

While assessments of need had been completed for residents, these were not consistently updated to reflect residents' changing needs. Personal plans were also developed; however the person in charge had identified the need to review and update all residents' personal plans in order to ensure clear and up-to-date guidance in the provision of care and support for residents. Personal plans were not developed for all healthcare need for residents.

Overall the inspector found the healthcare needs of residents were met and residents were supported to attend appointments for reviews with their general practitioners and allied healthcare professionals. However, some improvement was required to ensure a review with the mental healthcare team was facilitated for a resident.

Residents were supported to attend day services, and had access to arrange of amenities and activities both in the centre, and in the community. Residents were supported to maintain links with their families and friends, with visits, phone calls and meeting up for coffee.

Significant concern was identified with provision of behavioural support for some residents. Residents were not supported with timely access to a behaviour support specialist, in order to review their behavioural support plans in light of emerging risks and needs. An identified need for additional professional support, to help a resident with their emotional needs had not been facilitated, and accurate behaviour records were not being maintained in the centre. The oversight of restrictive practices in the centre required improvement.

Residents had not been protected by practices in the centre, and despite a known risk, a decision had been made by the provider to implement changes, resulting in a negative impact for residents. A safeguarding incident had not been identified as such, appropriately investigated, or followed up to highlight the risk, and put measures in place to support the resident and prevent re-occurrence.

Improvements was required in the oversight of risks in the centre. While some risks

had been assessed, a known risk which had contributed to adverse events in the centre, had yet to be identified in risk assessments, and clear arrangements set out to prevent re-occurrence. While incidents were reviewed locally by the management team, timely and corrective action was not consistently implemented.

Regulation 13: General welfare and development

Overall the inspector found residents were provided with a range of opportunities both in the centre, and in the community, and activities were facilitated based on the needs and preferences of the residents. For example, one of the residents told the inspector they were visiting some friends and going out for coffee on the day of inspection, and another resident who enjoyed playing video games, had ordered and number of games online recently. Residents had chosen to go on a day trip to a religious place of interest recently.

Residents could access day services full time and in one case where a resident had chosen to retire, staff continued to support the resident to visit their friends in day service and attend to some activities there specific to their interests.

Residents were supported to maintain family and personal relationships. One of the residents was visiting their family on the evening of the inspection, another resident had recently returned from a break at home, and another resident was supported to attend a significant family occasion recently. There were ample room in the centre to facilitate the interests of residents, including an outside cabin where residents enjoyed craft activities and listening to music.

Judgment: Compliant

Regulation 26: Risk management procedures

Improvements were required in the management and oversight of risks in the centre, in order to ensure risks were specifically outlined and corrective action taken to prevent re-occurrence.

The inspector reviewed records of incidents since the last inspection in January 2022. The person in charge told the inspector that, communication issues had led to two medication errors in May of this year, and that a contributing factor had been that staff on sleepover duty had been up supporting residents at night time. However, the inspector found that up until the day of inspection, a comprehensive review of staffing at night time had not been completed. While staff were requested to keep accurate sleep records, to track the support residents required at night time, this was not consistently being implemented. Some incidents had been followed up, for example, the mobility needs of a resident had been reviewed and the corresponding risk assessment updated, and as will be discussed some safeguarding

incidents had been followed up appropriately.

There were some assessments in place which identified specific risks for residents, and outlined the control measures to mitigate such risks. However, as mentioned a safeguarding risk was not reviewed or evidently actioned. While incidents were reported to the person in charge, and reviewed by the CEO, the oversight of risks from a board of management level were not clear, so as to assure the provider that risks were being effectively managed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' needs had been assessed and in most cases there were personal plans developed based on these needs; however, not all needs assessments were up-to-date, and reflective of the changing needs of residents. For example, the person in charge told the inspector that all residents' assessments of needs required to be reviewed and updated. Personal plans were developed for some identified needs of residents; however, there was no plan in place relating to a changing healthcare need of a resident, and another plan was not updated to reflect an allied healthcare professional recommendations.

Staff in the centre were responsible for the development of personal plans, and the person in charge was responsible for overseeing and signing off on personal a plans. However, a number of plans were not signed by the person in charge, who subsequently told the inspector that the details in most plans required to be reviewed and updated in order to ensure they provided adequate guidance to staff.

Judgment: Not compliant

Regulation 6: Health care

Notwithstanding the issue relating to healthcare plans, the inspector found most of the healthcare needs of residents had been met. There was ongoing monitoring within the centre, and by residents' general practitioners (GP) and allied healthcare professionals, of the healthcare needs of residents. However, in one case a review for a resident with the mental healthcare team had not been facilitated within the required timeframe, and there was no upcoming appointments arranged for this resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector reviewed two behaviour support plans and found the provision of positive behavioural support required improvement. In one case the behaviour support plan was up-to-date reflecting the needs and support requirements of a resident. However, the inspector found one resident was not being appropriately supported with their behavioural and emotional needs. The behaviour support plan had not been reviewed in light of emerging risks and a safeguarding measure, and the inspector was informed that residents were on a waiting list for a review of their behavioural needs. In addition, a need for additional support for a resident with their emotional needs had been identified a number of weeks ago; however, this support had not been sourced to date. Accurate behaviour records were not maintained in the centre, so as to inform reviews.

There was inadequate oversight of some restrictive practices in the centre, and the provider had not established a rights review committee to review practices, as reported in the previous inspection in January 2022. There were some restrictive practices in use in the centre, and some of these had been reviewed recently.

Another restrictive practice was reviewed by a keyworker monthly, and also by the management team, however, this practice did impact the rights of the resident. While the rationale for the use of the practice was clear, there was no plan in place to review this restriction with a multidisciplinary team, to ensure it was implemented relative to the known risk to the resident, and reported changing presentation.

Judgment: Not compliant

Regulation 8: Protection

Residents were not consistently protected by practices in the centre, and a decision by the provider to implement a change despite this being a known risk, put residents' safety at risk and impacted negatively on their wellbeing.

There had been some safeguarding incidents reported to HIQA since the last inspection, and these incidents had also been appropriately reported to the safeguarding office. Safeguarding plans had been developed and most were implemented; however, as mentioned in one case a review by a behaviour support specialist had not been facilitated.

In addition, the person in charge had noted in their report to the safeguarding office of the contributing factors, which had been the decision made by the provider to implement changes despite knowing the associated risks. This factor had not been identified as a safeguarding issue in itself, had not been appropriately investigated.

Similarly, there had been no risk assessment or safeguarding plan developed which

highlighted this risk, and control measures, which had evidently had a significant impact in the centre. Consequently the inspector was not assured that going forward, the provider had taken all the necessary steps to ensure residents were protected.
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 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Steadfast House Residential Service - Group Home OSV-0001631

Inspection ID: MON-0036633

Date of inspection: 23/08/2022

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: In order to meet compliance with Regulation 14: Person in Charge the following actions have been undertaken • An Additional Clinical Nurse Manager 1 has been appointed to support the Person in Charge in this centre from 09:00 to 13:00 daily Monday to Friday. • An additional 2 WTE Social Care Workers (Team Leaders) have been appointed to this centre to support the Person in Charge on a full-time basis in the Group Home. • Staffing has increased in the Centre. Current staffing levels are 1 Health Care assistant on from 21:00 to 10:00, One Social Care Worker on from 08:00 to 21:00 and 1 Health Care assistant on from 15:00 to 22:00 on weekdays when the residents are attending Day Services. The Person in Charge is also onsite from 08:00am to 13:00. The Clinical Nurse Manager 1 is rostered on from 09:00 to 13:00. • The roster will be reviewed by the Person In Charge on a weekly basis and additional staff will be provided to support residents at the weekends if required.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to meet compliance with Regulation 15: Staffing the following actions have been undertaken	

• An Additional Clinical Nurse Manager 1 has been appointed to support the Person in Charge in this centre from 09:00 to 13:00 daily Monday to Friday.

• An additional 2 WTE Social Care Workers have been appointed to this centre to support the Person in Charge on a full-time basis in the Group Home.

• The service has reviewed the current rota and sufficient staffing levels are available to support the resident's needs. The rota will continue to be reviewed by the Person in Charge.

• The Registered Provider will continuously review the staffing skill mix in line with the changing needs of the residents.

• Staffing has increased in the Centre. Current staffing levels are 1 Health Care assistant on from 21:00 to 10:00, One Social care worker on from 08:00 to 21:00 and 1 Health Care assistant on from 15:00 to 22:00 on weekdays when the residents are attending Day Services. The Person in Charge is also onsite from 08:00am to 13:00. The Clinical Nurse Manager 1 is rostered on from 09:00 to 13:00.

• The roster will be reviewed by the Person In Charge on a weekly basis and additional staff will be provided to support residents at the weekends if required.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In order to meet compliance with Regulation 23: Governance and Management the following actions have been undertaken

• An Additional Clinical Nurse Manager 1 has been appointed to support the Person in Charge in this centre from 09:00 to 13:00 daily Monday to Friday.

• An additional 2 WTE Social Care Workers have been appointed to this centre to support the Person in Charge on a full-time basis in the Group Home.

• The service has reviewed the current rota and sufficient staffing levels are available to support the resident's needs. The rota will continue to be reviewed by the Person in Charge.

• Incident Management Framework Policy will be reviewed to include the roles and responsibilities and appropriate pathway in reporting incidents by 15/10/22.

• The Chief Executive Officer will meet with the Board of Directors every month to discuss regulatory compliance and monitoring and operational service delivery. The agenda will include incident management, safeguarding, staffing, budgetary requirements etc.

• A full review of each resident's Personal Care Plan will be completed by 4/10/22.

• The Registered Provider Representative is a member of the Board of Directors.

• The PIC will complete the Judgement Framework on a quarterly basis and the actions identified will form part of the Quality Improvement Plan for the service.

• An experienced consultant has been procured by the Board of Directors and will meet with the Provider Representative on site on 5/10/22. The Consultant will support the Board of Directors in their roles and responsibilities in the first instance. The consultant will agree an improvement plan for the Board and oversee its implementation and further review its impact on service improvement.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to meet compliance with Regulation 26: Risk Management procedures the following actions have been undertaken

• Staffing has increased in the Centre. Current staffing levels are 1 Health Care assistant on from 21:00 to 10:00, One Social care worker on from 08:00 to 21:00 and 1 Health Care assistant on from 15:00 to 22:00 on weekdays when the residents are attending Day Services. The Person in Charge is also onsite from 08:00am to 13:00. The Clinical Nurse Manager 1 is rostered on from 09:00 to 13:00.

• A Clinical Nurse Specialist is reviewing and updating the resident's positive behavior support plan on the 4/10/22 in consultation with staff and will monitor these on regularly basis.

• A full review of the centre's risk will be undertaken by the Registered Provider and the Person in Charge to include existing control measures and additional control measures required.

• Any risk that cannot be managed will be escalated to the Board of Directors.

• Incident Management Framework Policy will be reviewed to include the roles and responsibilities and appropriate pathway in reporting incidents: - 15/10/22

• All category 1 incidents will be notified to the Board of Directors within 24 hours of occurrence.

• Incident management will be a standing agenda at monthly Board of Directors meetings, where serious incidents will be discussed.

• All individuals risk assessments will be reviewed to include all current safeguarding risks.

• All safeguarding plans to be reviewed in line with National Safeguarding Policy.

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:
In order to meet compliance with Regulation 5: Individual assessment and personal plans the following actions have been undertaken

• A full review of each resident's Personal Care Plan will be completed by 4/10/22.

• The Person in Charge has signed off on all Residents Personal centre plans.

• A Clinical Nurse Specialist is reviewing and updating the resident's positive behavior support plan on the 4/10/22 and will monitor these on a regular basis.

• An Additional Clinical Nurse Manager 1 has been appointed to support the Person in Charge in this centre from 09:00 to 13:00 daily Monday to Friday.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
In order to meet compliance with Regulation 6: Healthcare the following actions have

been undertaken

• The Mental Healthcare needs of the residents have been reviewed with the General Practitioner on the 14/9/22.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In order to meet compliance with Regulation 7: Positive Behavioral Support the following actions have been undertaken

• A Clinical Nurse Specialist is reviewing and updating the resident's positive behavior support plan on the 4/10/22 and will monitor these on a regular basis.

• The Senior Clinical Psychologist met with resident on the 27/9/22.

• The Senior Clinical Psychologist and the Clinical Nurse Specialist will facilitate training for the staff on Positive Behavior Support and the recordings of behaviors on the 19/10/2022.

• The Clinical Nurse Specialist is reviewing all restrictive practices used within the Centre.

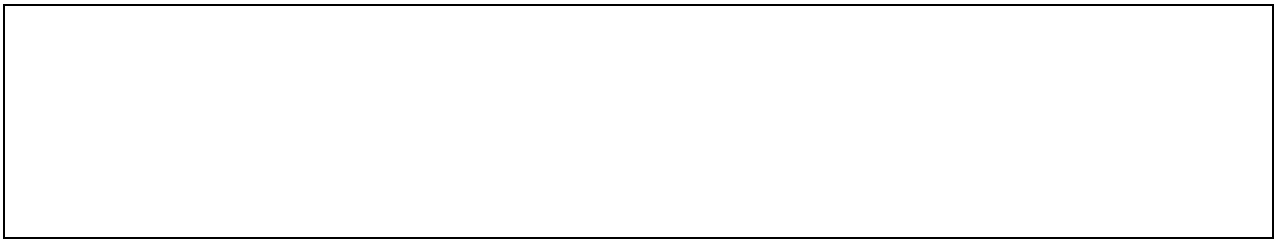
Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In order to meet compliance with Regulation 7: Protection the following actions have been undertaken:

• The Risk Register for the Centre has been updated to include the identified risk.

• A preliminary Screening will be completed for the safeguarding incident identified and will be submitted to the safeguarding team.

• All staff to complete refresher safeguarding training by 15/10/22.



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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	05/10/2022
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.	Not Compliant	Red	05/10/2022
Regulation	The registered	Not Compliant		05/10/2022

23(1)(a)	provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.		Orange	
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	05/10/2022
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.	Not Compliant	Orange	05/10/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Not Compliant	Orange	15/10/2022

	ongoing review of risk, including a system for responding to emergencies.			
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	04/10/2022
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	04/10/2022
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal	Substantially Compliant	Yellow	14/09/2022

	plan.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	10/10/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	06/10/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	15/10/2022