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:	Ardbrae
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	03 February 2022
Centre ID:	OSV-0001700
Fieldwork ID:	MON-0035692

About the designated centre

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

Ardbrae is a designated centre operated by Sunbeam House Services CLG. The designated centre is located in a town in County Wicklow. It provides full-time residential service for up to four adults with an intellectual disability. The centre is a two-storey dwelling comprising of two joined houses which consists of a kitchen, living room, three individual living rooms for residents, staff sleepover room, office and two shared bathrooms. Each resident has their own personal bedroom (three of which have en-suites). There is a small garden to the rear of the building. The centre is staffed by a person in charge, (who is also employed as a person in charge for one other centre), social care workers, day facilitators and sleepover staff.

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
Thursday 3 February 2022	10:00hrs to 19:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The inspector found that the person in charge and staff were endeavouring to ensure that the wellbeing and welfare of residents living in the centre was maintained by a good standard of evidence based care. However, there were compatibility issues in the centre which was impacting negatively on the lived experience of residents. A number of residents who spoke with the inspector advised that they were finding it difficult living with some of their fellow peers. They expressed that their health and wellbeing was being negatively impacted by the incidents occurring in the house.

On the day of the inspection, the inspector met with all four residents who were living in the centre. All residents were happy to show the inspector their bedroom and their own individual sitting room. As much as possible, engagement between the inspector and the residents took place from a two-metre distance and wearing the appropriate personal protective equipment in adherence with national guidance.

Residents expressed themselves through their personalised living spaces. To support compatibility issues in the house and to provide some "time out" alone, residents were provided with their own sitting room area. Overall, residents' rooms were decorated to their likes and preference. Many of the rooms included family photographs, pictures and paintings on the walls including residents own personal items of interest. Some of the residents told the inspector that they were happy with their bedroom however, one resident expressed that they wanted to move to another room as it was nearer to their individual sitting room which included their additional wardrobe. They also advised that they were having difficulty sleeping as their current room was located in an area where they could hear another resident vocalising loudly during the night.

In addition to the residents' own individual spaces, there was a communal dining area, sitting room and kitchen down stairs. However, improvements were needed to the layout of the kitchen so that it met the assessed needs of all residents. Furthermore, on the day of the inspection, the inspector observed that an urgent improvement was needed to the cleanliness of all areas of the house.

Two of the residents requested to speak with the inspector privately. They expressed that at times they found it difficult sharing their home with some of the other residents. They told the inspector that they found it hard to be in the company of some residents when they were speaking loudly, crying or shouting. Overall, they said that this was impacting on their health and wellbeing in a negative way. Residents appeared visibly upset when they relayed this information to the inspector. The residents said they were happy to have their own sitting room and liked having their own space however, found it difficult spending time in communal areas with some of their peers. On one occasion, while speaking with three residents in the communal sitting room, the inspector observed two residents appear upset and walk out of the room in direct response to another resident

entering the room.

Pre-COVID-19, the residents attended their own individual day services for most days of the week however, this had changed and residents were now in receipt of a type of day service from their home. As such, residents were now spending more time together as a group rather than individually. Residents were supported by their staff and day facilitator to engage in community activities. There was an activity plan in place however, it was limited in its flexibility. On-site and community activities (including staffing requirements) had to be navigated to reduce the risk of compatibility related behavioural incidents occurring in the house and more recently, due to the changing health needs of some residents. Through speaking with the person in charge and staff including a review of documentation, it was evident that the health and behavioural needs of some residents were changing and required increased one to one support from staff.

Residents and their families were consulted in the running of the centre and played an active role in the decision making within the centre. Residents' meetings were occurring, however, more recently, to mitigate the risk of behavioural incidents between residents, the meetings had been held on a one to one basis between a staff member and each resident. On a review of a sample of meetings, the inspector found that many of the discussions at the meetings centred around residents upset (and at times fears) regarding their peers behaviours and how it was impacting their health and wellbeing. However, discussions also included matters such as activity plans, likes and preferences and keeping up to date on how to keep safe during the currently health pandemic.

Residents were also supported to be knowledgeable and aware of how to make a complaint. Two of the residents told the inspector that they had made complaints about matters relating to incidents occurring in the house and how it was impacting them. Overall, they expressed their lack of confidence in the system as they felt the issue had not being resolved. Overall, the inspector found that a number of changes and supports had been put in place to try respond to residents' complaints however, as the compatibility issues were still in place, the complaint remained on-going.

Residents also told the inspector that they had been previously asked by senior management if they wanted to move to another location, however, residents had expressed that that was not what they wanted. Overarching safeguarding plans demonstrated that there was conversations between the residents, senior management and the organisation’s housing officer, around options to move location. However, the inspector found that where a resident had previously requested to move house, that at the time, there was no tangible option available to them and that they were placed on a transfer list until something suitable arose.

In summary, the inspector found that overall, due to the on going compatibility issues between residents and the changing health and behavioural needs of some residents (including adequate staffing levels in place to support these needs), the provider had not fully ensured that the residents’ well-being and welfare was maintained to a good standard at all times. In addition, due to the uncleanliness of areas of the house, the provider had failed to ensure that there were adequate

precautions in place to prevent and reduce the risk of the transmission of infection. Subsequent to the inspection, the provider submitted a comprehensive action plan for the house to be cleaned with many of the actions competed on or immediately after 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 to each resident living in the centre.

Capacity and capability

The inspector found that management systems in place did not adequately ensure that the service provided was safe, appropriate to the residents' needs or effectively monitored, at all times. There was a significant increase of non-compliance found on this inspection compared to the last inspection in October 2020. In particular, the non-compliance found in regulation 27, protection against infection, resulted in an urgent action plan being issued to the registered provider. The provider subsequently submitted a response and provided comprehensive assurances that the risk was adequately addressed.

The provider had put monitoring systems in place in the centre to ensure the upkeep and cleanliness of the centre however, on the day of inspection, these had been found to be ineffective. For example, the local household audit which reviewed the cleanliness of the house on a monthly bases, had been carried out the day prior to the inspection, however, it had not identified the majority of the issues observed on the day. In addition, a review of the monitoring systems in place for the daily cleaning schedule was also required. This was to ensure that, where cleaning tasks could not be completed on a specific day, that there were arrangements in place to follow up and ensure their completion.

The provider had identified that there were compatibility issues within the centre. An overarching safeguarding plan had been implemented since 2019 which included ongoing actions to support the reduction of incidents occurring in the house and to mitigate the risks associated with the incidents. The person in charge reviewed, updated and submitted a copy of the plan to the appropriate agency on a six monthly basis. The plan included updates on multidisciplinary meetings, behaviour support engagement and strategies put in place in an attempt to reduce the compatibility issues in the house. However, while there had been some improvements, overall, the plan was not fully effective and compatibility issues remained in the residents' home. In turn, this had a negative impact on the lived experience of residents.

The provider had not adequately ensured that the layout of the house was meeting the needs of all residents, at all times. The provider had organised an environmental assessment of the location to determine the cause of non-serious injuries for one

residents. The report recommended structural changes to the layout of the kitchen. On the day of the inspection, there were no plans or timelines in place to carry out this work, however, the inspector was advised that a large scale structural change to the house was currently being explored. This was in an effort to address the compatibility issues in the house, while at the same time, meet the health and wellbeing needs' of all residents. However, as this plan was just at the exploratory stage, the inspector found that the provider was not operating in a manner that ensured residents were residing in a suitable environment to meet their assessed needs, at all times.

On the day of inspection, the inspector found that the number of staff employed was in line with the centre's statement of purpose. For the most part, there were two staff supporting residents during week and weekends. On review of documentation and speaking with staff, it was evident that a number of residents required one to one support throughout different times of the day. For example, some residents' personal plans demonstrated that they required one to one support with their personal care needs, health and medical needs, dietary and food intake needs and when out and about in the community. The inspector found that overall, to ensure the changing needs of residents were met, alongside ensuring residents enjoyed a wide choice of community activities, in addition to managing the ongoing compatibility issues in the house, a review of the current staffing levels in the centre was needed.

In addition, on review of a sample of cleaning schedules, the inspector found that some of the required daily cleaning tasks had not always been marked as completed. The inspector was advised that the tasks were not always completed due to the time required to support the needs of residents and in particular, when a behavioural incident occurred and residents required additional support due.

Notwithstanding the above, the inspector found that there were arrangements in place for continuity of staffing so that support and maintenance of relationships were promoted. A core team of staff were employed in this centre with many of the staff working for a continuous period of three years or more. Staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre. The inspector observed attentive, kind and caring interactions between the staff and residents through-out the inspection. From speaking with the person in charge and staff, it was evident that they were endeavouring to ensure that the wellbeing and welfare of residents living in the centre was maintained by a good standard of evidence based care.

There were clear lines of accountability at individual, team and organisational level so that staff working in the centre were aware of their responsibilities and who they were accountable to. A new person participating in management (PPIM) commenced their role in December 2021, three weeks after the previous PPIM ceased their role. Staff team meetings were taking place regularly which promoted shared learning and supported an environment where staff could raise concerns about the quality and safety of the care and support provided to residents. Safeguarding was included on all meeting agendas and behavioural incidents, including supports, was regularly

discussed. Staff informed the inspector that they felt supported by the person in charge, were in receipt of regular one to one supervision meetings and that they could approach the person in charge at any time in relation to concerns or matters that arose.

There was a complaints procedure in place in the centre that was in an accessible and appropriate format which included access to a complaints officer when making a complaint or raising a concern. However, the inspector found that where some complaints had been raised, that were similar in topic, a review of the way they were recorded, and dealt with, was needed. For example, residents had raised a number of complaints relating to compatibility issues in the house and how it was impacting on their health and wellbeing. These complaints had been addressed as an overall complaint rather than each complaint being dealt with on an individual basis. In addition, these complaints had not been appropriately followed up in line with the organisation's complaints and compliments policy.

Regulation 15: Staffing

Staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of the resident.

To ensure the changing needs of residents were met, alongside ensuring residents enjoyed a wide choice of community activities, in addition to managing compatibility issues in the house, a review of the current staffing levels in the centre was needed.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, the provider had not adequately ensured that their own governance and oversight arrangements were being followed. The inspector found that the management systems in place did not ensure that the service provided was safe, appropriate to the residents' needs or effectively monitored, at all times.

The inspectors found that a number of the local monitoring and auditing systems in place in the centre were not always effective in identifying and addressing improvements required to ensure a safe and good quality service was being provided to the residents living in the designated centre.

Due to on-going compatibility issues in the centre, the provider was not operating in a manner that ensured residents were living in a suitable environment to meet their assessed needs or were safe at all times. Overall, this was impacting negatively on

the lived experience of residents.

In addition the provided had not ensured that the layout of the centre was meeting the assessed needs of residents at all times.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found that improvements were needed to the information governance arrangements in place to ensure that the designated centre complied with notification requirements. For example, not all incidents were notified as appropriate to the Office of the Chief Inspector in line with Regulation 31. Overall, a review of all incidents was needed to ensure, that where they met the threshold, they were notified to the Chief Inspector as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints procedure in place in the centre that was in an accessible and appropriate format which included access to a complaint's officer when making a complaint or raising a concern. However, where some complaints had been raised, that were similar in topic, a review of the way they were recorded and dealt with was needed. In addition, these complaints had not been appropriately followed up in line with the organisation's complaints and compliments policy.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that the provider had failed to ensure that the designated centre was achieving the basic quality and safety standards required by the regulations in relation to protection against infection. In addition, due to ongoing compatibility issues in the centre, other areas relating to the quality of care and support provided to residents required improvement. This was to ensure that residents were living in a safe environment, that met their needs and empowered them to live life as independently as they were capable of.

There were infection control risks posed to residents due to poor levels of cleaning

and maintenance in the designated centre. Many areas of the house required attention and upkeep. For example, the designated centre was observed to be unclean in a number of areas including, the floors of residents' bedroom and en-suite, the laundry room, food storage facilities, but to mention a few. In addition to the cleanliness factor, damaged and compromised fixtures, fittings, and furniture posed as risk for the spreading of bacteria and infections. For example, there was chipped walls, doors and door frames throughout the house. There was grime found on a shower's tiles and soap holder, an extractor fan was dirty, there were cobwebs on ceilings and rust and peeling enamel on a radiator.

However, in relation to infection prevention and control measures specific to COVID-19, for the most part, there were satisfactory contingency arrangements in place in case of infection. The registered provider had a COVID-19 contingency plan, which included guidance on infection prevention and control measures, the management of suspected or confirmed cases of COVID-19 among residents and staff, and contingency plans in relation to staffing and other essential services. All staff had completed specific training in relation to the prevention and control of COVID-19 and on the day of inspection, staff were observed to be adhering to public health guidance in the appropriate use of face masks, hand hygiene and social distancing.

The physical environment of the house required decorative and structural repair work. A number of walls, doors and door frames needed paintwork. In addition, the current layout of the premises was not meeting the needs of all residents, at all times. While the provider had organised individual sitting rooms for three residents, the overall layout of the environment was contributing toward compatibility issues between the residents. In addition, as per recommendations by an allied health profession, the layout of the kitchen needed to be changed, to mitigate the risk of further non-serious injuries for a resident.

The inspector found that although the provider had implemented strategies to reduce the compatibility issues in the house, the overall impact of the incidents was effecting the residents' lives in a negative manner. The person in charge and staff were endeavouring to managed the situation through navigating timetables and schedules to reduce interactions between residents in communal areas of the house. For example, residents' meal times were staggered. There was an overarching safeguarding plan in place which had been reviewed and updated in January 2022. Through conversations with residents, staff, and through a review of documentation, the inspector found that on many occasions, behavioural incidents between residents had resulted in residents feeling upset and worried about how it was impacting their health and wellbeing. The inspector found, that while the current living arrangements were in place, the risk of continued behavioural incidents remained, and as such, the provider could not be assured that residents were protected from all forms of abuse, at all times.

The inspector reviewed the arrangements in place to support residents' positive behaviour support needs. The provider and person in charge promoted a positive approach in responding to behaviours that challenge. Residents had access to members of a multidisciplinary team, including the centre’s behavioural support specialist, to support them to manage behaviour positively. Where necessary,

residents had positive behaviour support plans, which were informed by an appropriate professional and comprehensively guided staff in the delivery of care. The person in charge had identified the changing behavioural needs of one resident and the positive behavioural specialist had been contacted to review the resident's plan. While there was evidence to demonstrate that the implementation of a behaviour support plan for one resident had reduced behaviours of concern, overall, continuous positive behaviour support input was needed to support the reduction of the compatibility issues in the house.

There are a number of restrictive practices in place in the centre. Although there was a review of the restrictive practices by the organisation's rights restriction committee completed on a regular basis, not all documentation associated with the practices were in line with the organisation's restrictive practice policy. For example, documentation to demonstrate the rationale for the restriction, the risk assessment or a reducing (or fading out) plan was not included in all residents personal plans.

The inspector reviewed a sample of residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs. Support plans that endeavoured to meet the residents' assessed needs were implemented and regularly reviewed. Residents, and where appropriate their family members, were consulted in the planning and review process of their personal plans. Overall, where changes occurred in residents lives, their plan were updated. There was an auditing system in place to ensure residents' plans were kept up to date. On review of the sample of plans, the inspector saw that the person in charge had identified and noted updates required to each of them. However, overall, the registered provider had failed to put arrangements in place to meet the needs of each resident, as per the assessed needs in their personal plan. In addition, the layout of the premises of the designated centre was not suitable for the purpose of meeting the needs of each resident.

Regulation 17: Premises

The physical environment of the house required decorative and structural repair work. A number of walls, doors and door frames needed paintwork. In addition, the currently layout of the premises was not meeting the needs of all residents, at all times. While the provider had organised individual sitting rooms for residents, (who wished to have them), the overall layout of the environment was contributing towards compatibility issues between the residents.

In addition, recommendation made by an allied health profession for the layout of the kitchen to be changed, to mitigate the risk of further non-serious injuries for a resident, had not been implemented; There were plans to change the layout of the centre however, these were at the exploratory stage.

Judgment: Not compliant

Regulation 26: Risk management procedures

For the most part, the inspector found that appropriate individual and location risk assessments were in place which endeavoured to ensure that safe care and support was provided to residents living centre.

However, on the day of the inspection, the inspector identified two risks which had the potential to impact on the safety of residents living in the centre.

The staff sleepover door and a resident's sitting room door (both fire doors) were observed to be held open by large objects.

A mobile phone was observed lying on the carpet floor of a resident's bedroom while being charged.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were infection control risks posed to residents due to poor levels of cleaning and maintenance in the designated centre.

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurances that the risk was adequately addressed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs. Support plans that endeavoured to meet the residents' assessed needs were implemented and regularly reviewed. On review of the sample of plans, the inspector saw that the person in charge had identified and noted updates required to the plans.

However, as addressed in Regulation 23, 17 and 8, the registered provider had failed to put arrangements in place to meet the needs of each resident, as per the assessed needs in their personal plan. In addition, the layout of the premises of the designated centre was not suitable for the purpose of meeting the needs of each

resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider and person in charge promoted a positive approach in responding to behaviours that challenge and endeavoured to ensure that evidence-based specialist and therapeutic interventions were implemented.

Not all documentation associated with restrictive practices were in line with the organisation's restrictive practice policy. For example, documentation to demonstrate the rationale for the restriction, the risk assessment or a reducing (or fading out) plan was not included in all residents' personal plans.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that although the provider was endeavouring to manage and implement strategies to reduce the compatibility issues in the house, the overall impact of the incidents was effecting the residents' lives in a negative manner.

Overall, while the current living arrangements were in place, the risk of continued behavioural incidents remained and as such, the provider could not be assured that residents were protected from all forms of abuse at all times.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ardbrae OSV-0001700

Inspection ID: MON-0035692

Date of inspection: 03/02/2022

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: A Personal Assistant will be recruited to provide one-on-one supports for one client. The purpose of the role will be to facilitate a hybrid support system which will include a mix of day service and community-based activities. This role will operate Monday to Friday from 10:00-18:00 daily. The role will be advertised week ending 25.02.22. It is proposed the suitable candidate should be in place by 30.06.22. Pending successful recruitment and compliance. A cleaner will be recruited for an additional few hours monthly to provide additional supports to the location. This support will also be in place by 30.04.22.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Rooms in upstairs will be reconfigured with minor works and additions to allow a client to move bedroom and a dedicated space for one resident this has been identified to be a key part to address the compatibility / safeguarding concerns. This will be done is phases over the 12 weeks. 12 Weeks over period from 21.2.22 – 20.5.22 New auditing measures have been implemented from 07.02.22. The PIC will implement a new weekly household audit. This will link in with the shift leader checklist. This will allow the PIC full oversight on a weekly basis and identify areas where gaps have occurred and	

implement actions in relation to same.

The full monthly household inspection audit will remain in place however updates have been included to the form such as including COVID and infection control checks.

A shift leader has been allocated on shift each day. This has been identified on the roster using colour coding. The shift leader is responsible for task allocation. The shift leader will ensure all tasks are completed. Any tasks which were not completed will be handed over to the next day and noted on the handover sheet. An explanation for why it was not possible to complete the task must be noted. This will then be reviewed on a weekly basis by the PIC to highlight any areas of concern or where additional supports may be required in relation to cleaning and infection control as part of the weekly household inspection audit.

Daily cleaning schedules were reviewed and updated to include areas which were previously missing for example cleaning of windowsills, removal of cobwebs and supporting clients daily with making their beds, opening their curtains, putting away their night clothes and emptying their bins.

A weekend deep clean checklist has also been implemented. This will be managed by the shift leader and tasks allocated as appropriate.

A full deep clean of the location including carpets has been contracted to Ashford Cleaning and this commenced on 11.02.22.

A cleaner will be recruited for an additional few hours monthly to provide additional supports to the location. This support should be implemented from first week of April. CK cleaning company has been contracted to clean the location for 3 hours per week.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC will review all issues of concern from 01.05.20, until 03.02.22, the date of the inspection and if required will submit any issues of concern which meet the threshold and therefore require an submission of an NF06s retrospectively. This will be completed no later than 31.03.22. Any issues of concern which meet the threshold and therefore require submission of an NF06 notification has occurred since 03.02.22.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Consultation with Sunbeam Complaints officer and Quality and Compliance Manager SHS on 22/23.3.22

Effective 24.3.22 PIC instructed to log all complaints and to discontinue the practice of excluding under section 8.

All complaints will be logged, if there is a safeguarding element this will be stated in the complaint referencing the Preliminary Screening number, it will be initially stated in the body of complaint and the complaint will be left open on the system, upon acceptance of Safeguarding Action plan these actions will then be entered into the complaint as an update and then discussed with resident to see if they are satisfied with the outcome of complaint.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Building and repair works as highlighted on urgent action plan dated 04.2.22 were all uploaded to Flexmaint system. Contractors to assess and cost works by 18.02.22, duration of works 3 to 5 days. Estimated completion date of works will be no later than 30.3.22, exact date will be confirmed when contractors assess works.

The layout of the kitchen and recommendations from OT report will also be addressed and the works will be completed by 20.5.22

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The practice of wedging 2 fire doors open was ceased with immediate effect on the day of the inspection. It was also discussed at the staff meeting and it was decided that some doors require to be left open. Request for appropriate door closers was put to Flexmaint and this will be completed by 20.5.22

Staff have completed key working with the resident to ensure the resident is supported

to charge their mobile phone in a safe manner.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Actions outlined in urgent action plan was submitted and accepted on 08.02.22.

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:
Rooms in upstairs will be reconfigured with minor works and additions to allow a client to move bedroom and a dedicated space for one resident this has been identified to be a key part to address the compatibility / safeguarding concerns.

This will be done is phases over the 12 weeks. 12 Weeks over period from 21.2.22 – 20.5.22

New auditing measures have been implemented from 07.02.22. The PIC will implement a new weekly household audit. This will link in with the shift leader checklist. This will allow the PIC full oversight on a weekly basis and identify areas where gaps have occurred and implement actions in relation to same.

The full monthly household inspection audit will remain in place however updates have been included to the form such as including COVID and infection control checks.

A shift leader has been allocated on shift each day. This has been identified on the roster using colour coding. The shift leader is responsible for task allocation. The shift leader will ensure all tasks are completed. Any tasks which were not completed will be handed over to the next day and noted on the handover sheet. An explanation for why it was not possible to complete the task must be noted. This will then be reviewed on a weekly basis by the PIC to highlight any areas of concern or where additional supports may be required in relation to cleaning and infection control as part of the weekly household inspection audit.

Daily cleaning schedules were reviewed and updated to include areas which were

previously missing for example cleaning of windowsills, removal of cobwebs and supporting clients daily with making their beds, opening their curtains, putting away their night clothes and emptying their bins.

A weekend deep clean checklist has also been implemented. This will be managed by the shift leader and tasks allocated as appropriate.

A full deep clean of the location including carpets has been contracted to Ashford Cleaning and this commenced on 11.02.22.

A cleaner will be recruited for an additional few hours monthly to provide additional supports to the location. The cleaner will come once a week and it will be implemented by 31.3.22.

Building and repair works as highlighted on urgent action plan dated 04.2.22 were all uploaded to Flexmaint system. Contractors to assess and cost works by 18.02.22, duration of works 3 to 5 days. Estimated completion date of works will be no later than 30.3.22, exact date will be confirmed when contractors assess works.

The layout of the kitchen and recommendations from OT report will also be addressed and the works will be completed within the time frame of 12 weeks which should be completed by 20.5.22

Rooms in upstairs will be reconfigured with minor works and additions to allow a client to move bedroom and a dedicated space for one resident this has been identified to be a key part to address the compatibility / safeguarding concerns.

A Personal Assistant will be recruited to provide one-on-one supports for one client. This role will operate Monday to Friday from 10:00-18:00. The purpose of this role will be to provide additional supports to one client. This will address the additional needs of this client; it will allow them to access additional supports and activities offsite which will in turn positively impact on the incompatibility issues in the location. The role will be advertised week ending 25.02.22. It is proposed the suitable candidate should be in place by 30.04.22.

A review of the overarching safeguarding plan was completed with the CH06 Safeguarding and Protection Team and on agreement this will be reviewed to reflect the changes proposed in the location no later than 31.03.22.

Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive	

behavioural support:
Positive Behaviour Support Specialist is currently reviewing PBSP plans and implementing new strategies to manage behaviours and offer support to staff. Positive Behaviour Support Specialist attended staff meeting in 2nd March 2022 to discuss the next steps. All rights restrictions are submitted electronically with rationale for restriction and a comprehensive list of questions which form an assessment. This is viewed by the Human Rights Committee. The designated centre has a restrictive practices log. This will be reviewed to include details on reduction and fade out strategies. The restrictive practice log will be reviewed by 31.3.22

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Rooms in upstairs will be reconfigured with minor works and additions to allow a client to move bedroom and a dedicated space for one resident this has been identified to be a key part to address the compatibility / safeguarding concerns.

This will be done is phases over the 12week period from 21.2.22 – 20.5.22

A Personal Assistant will be recruited to provide one-on-one supports for one client. The purpose of the role will be to facilitate a hybrid support system which will include a mix of day service and community-based activities. This role will operate Monday to Friday from 10:00-18:00. The purpose of this role will be to provide additional supports to one client. This will address the additional needs of this client; it will allow them to access additional supports and activties offsite which will in turn positively impact on the incompatibility issues in the location.

The role will be advertised week ending 25.02.22. It is proposed the suitable candidate should be in place by 30.04.22.

A review of the overarching safeguarding plan was completed with the CH06 Safeguarding and Protection Team and on agreement this will be reviewed to reflect the changes proposed in the location no later than 31.03.22.

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 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	30/06/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	20/05/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/03/2022

	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.	Not Compliant	Orange	31/03/2022
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	20/05/2022
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.	Substantially Compliant	Yellow	20/05/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are	Not Compliant	Orange	31/03/2022

	protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/03/2022
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	31/03/2022
Regulation 34(2)(d)	The registered provider shall ensure that the	Substantially Compliant	Yellow	31/03/2022

	complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	31/03/2022
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/03/2022
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	20/05/2022
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of	Substantially Compliant	Yellow	20/05/2022

	meeting the needs of each resident, as assessed in accordance with paragraph (1).			
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.	Substantially Compliant	Yellow	31/03/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	20/05/2022