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:	Orchard Grove Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	24 April 2024
Centre ID:	OSV-0001756
Fieldwork ID:	MON-0043016

About the designated centre

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

Orchard Grove Residential Service is a centre run by Western Care Association. The centre provides residential care for up to three male or female residents, who are over the age of 18 years and who have an intellectual disability and an acquired brain injury. It comprises of one premises which is located on the outskirts of a town in Co. Mayo, providing residents with their own bedroom, en-suite facilities, shared bathroom, dining and kitchen area, multiple sitting rooms and access to a large front and rear garden. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 24 April 2024	09:45hrs to 17:20hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This centre is run by Western Care Association in Co. Mayo. Due to concerns about the governance and oversight of Western Care Association centres and its impact on the wellbeing and safety of residents, the Chief Inspector of Social Services undertook a targeted safeguarding inspection programme which took place over two weeks in March 2023 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection), regulation 23 (Governance and management) and regulation 26 (risk management procedures). The overview report of this review has been published on the Health Information and Quality Authority (HIQA) website. In response to the findings of this review, Western Care Association submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, but also to assess whether the actions of Western Care Association have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Mayo. At the time of the inspection the provider had completed a number of actions while others had been commenced and were in progress. The governance arrangements had been strengthened through the assessment of senior and frontline management structures. Service areas had been reconfigured. There were additional multidisciplinary supports available.

In this centre, there were clear lines of accountability and arrangements in place to maintain oversight of the service. Staff were familiar to the residents and knowledgeable of their needs. Residents were supported to engage in activities of their choosing and their rights were respected. Improvement was required in relation to fire safety checks, the development of personal plans in an accessible format for residents and ensuring that behaviour support plans were developed with the input from relevant professionals.

The centre consisted of a large bungalow located at the edge of a town. The house had three bedrooms. Two of the bedrooms had en-suite bathrooms with level access showers. There was a bathroom next to the third bedroom. In addition, there was a separate shower room. The centre had a kitchen-dining room, two sitting rooms and a large living room. The centre also had an office and there was a bedroom used by sleepover staff. The house was set on a very large site. The large gardens to the front and rear of the building were well maintained. The person in charge reported that the driveway to the front and side of the house had recently been replaced. This meant that there was a level access path around the building. The house was accessed at the front via a ramp.

The centre was registered to accommodate three residents but, on the day of inspection, only two residents were living there. The person in charge reported that there were no immediate plans for a new resident to move into the centre. The house was clean, tidy and in a good state of repair. The residents' bedrooms were

furnished and decorated to their own tastes. Residents' photographs and belongings personalised their bedrooms and living spaces. There was suitable storage for resident's personal possessions. The centre was configured so that one resident's bedroom was located next to one of the sitting rooms. This room was used exclusively by this resident. The provider had put some sound proofing materials in the room. The person in charge reported that this was for the resident's comfort and to reduce noise so that other residents were not disrupted. The sitting rooms had televisions and were comfortably furnished. Some rooms contained equipment for sensory activities.

The inspector had the opportunity to meet with both of the residents. Residents left the centre at different times during the day to engage in activities that they enjoyed. Residents spent time relaxing in the sitting room watching a television show of their choosing. One resident spent time completing a craft activity. When the inspector asked one resident if they were happy in their home, they responded 'I couldn't be more content'. They said that staff were very nice and that staff treated residents with respect. When discussing their rights, a resident reported that they knew that they had the right to vote and that they would vote in an upcoming election if they wanted to. They commented on the improved driveway around the house and that it was 'much easier to get around'. They said that they would tell staff if they had any complaints.

Staff in the centre interacted with the residents in a warm and friendly manner. In addition to the person in charge and team leader, the inspector had the opportunity to meet with two other members of staff. All were very knowledgeable on the needs of the residents and the supports they required to meet those needs. They were very familiar with the residents' routines and preferences. They spoke about the residents warmly and respectfully. They were knowledgeable on safeguarding procedures and what to do should any safeguarding concerns arise.

Overall, the inspector noted that residents in this centre received a good service that was in line with their needs and preferences. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

The provider had established clear lines of accountability and arrangements had been made to maintain oversight of the service. Some improvement was required in relation to these arrangements to ensure that service improvement issues were identified and addressed.

The provider had arrangements in place to maintain oversight of the service. When incidents occurred, these were recorded, escalated and analysed. There was evidence that incidents were reviewed in the centre and throughout the organisation

to identify any trends. Actions to reduce the risk of reoccurrence were identified. Oversight was also maintained through a suite of audits in the centre and through six-monthly senior management audits. The audits in the centre were completed in line with the provider's schedule. However, the quality of information obtained through these audits did not always identify areas for service improvement. For example, the monthly financial audits listed tasks that needed to be completed rather than identifying actions that should be taken to identify and address issues.

The staffing arrangements in the centre were suited to the needs of residents. Staff had largely up-to-date training in the modules that the provider had identified as mandatory. Staff knew who to contact if an issue arouse. The lines of accountability were clearly defined. However, the on-call arrangements in the centre were not adequately robust to ensure that a member of management could be contacted outside of regular hours. There was a system in place where staff were instructed to contact their line manager and to move to a more senior manager if they were unavailable. There was no roster for out of hours cover. This meant that managers were effectively on call at all times. This was not sustainable or sufficiently robust.

Regulation 15: Staffing

The number of staff employed in the centre was suitable to meet the needs of residents.

The inspector reviewed the current roster and the roster for the month prior to the inspection. This demonstrated that the staffing numbers were adequate at all times to support residents with their identified needs. Additional staff were also available two evenings a week to support residents engage in social activities. The person in charge reported that these shifts were flexible so that residents could be supported to go on social outings when they wanted. The staff was consistent in the centre meaning that staff were familiar to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The record of staff training was reviewed. It was noted that staff had up-to-date training in most of the modules that the provider had identified as mandatory.

Only one member of staff had completed face-to-face training in safeguarding but all staff had completed the online module. The person in charge reported that all staff had been nominated to attend face-to-face training in safeguarding.

Judgment: Compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 12 actions aimed at improving governance arrangements at the centre. The provider aimed to have all actions completed by 31 January 2024. At the time of the inspection, eight actions had been implemented with the remainder in progress.

Completed actions included:

- a review of senior management structure
- a reconfiguration of service areas
- the development of a service improvement team
- scheduling of six-monthly unannounced audits of centres and allocating a manager from outside of the region to complete these audits
- the re-establishment of an incident review committee
- the re-establishment of the human rights committee
- the development of a monthly improvement framework
- most staff had attended regulatory information events with dates scheduled for the following months to ensure that all staff received training.

The four actions that were in progress can be summarised as follows:

- The assessment and review of frontline staff was ongoing and on-call arrangements had not been addressed in this centre
- The review of local audits had not commenced. The person in charge reported that there was a plan for local audits to be reviewed by the Quality, Safety and Service Improvement Team but there were no dates identified as yet for this review.
- The new training system was piloted in two areas but not yet rolled out across the organisation
- The provider had completed the final draft of the policy and procedure framework but this had not yet been circulated to staff.

In this centre, the lines of accountability were clearly defined. Staff knew who to contact should any issues arise. However, the arrangements for contacting a member of management outside of regular hours required review. On the day of inspection, there was no roster of out-of-hours management cover. There was a system whereby managers were listed by hierarchy and staff were directed to begin by contacting their immediate line manager. If that manager was unavailable, staff were directed to continue to the next level of management until they received a response. This meant that managers were effectively on-call at all time and that the director of operations had to be contactable at all times. This system was not sufficiently robust to ensure that staff could escalate any incidents or emergencies

when they arose and receive a response in a timely manner.

The provider maintained oversight of the service through the review of incidents and through audits. The incidents for 2024 were reviewed on this inspection. It was noted that incidents in the centre were reported and escalated appropriately. Incidents in the centre were reviewed quarterly by the person in charge to identify any trends or actions that may be needed to avoid a reoccurrence.

The provider had a suite of audits in the centre. There was a schedule that outlined which audits should be completed monthly, quarterly or annually. A review of the audits completed in 2024 found that they were broadly completed in line with this schedule. However, the quality of information obtained through these audits did not always identify areas for service improvement. For example, the audits of residents' personal plans recorded all findings but did not highlight areas requiring action, the person responsible for completing this action, or evidence that previous audit findings had been addressed.

The provider had completed an unannounced audit of the quality and safety of care and support in the centre on 26 February 2024. The revised template, as outlined in the provider's compliance plan, had been used for this audit. This had identified 16 actions for service improvement with target dates for their completion.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose for the designated centre was submitted as part of the application to renew the registration of the centre and was reviewed. It contained the required information as set out in the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed the incidents in the centre that had occurred in 2024 and found that all required notifications had been submitted to the Chief Inspector in line with the regulations.

Judgment: Compliant

Quality and safety

The service delivered in this centre was of a good quality. Residents were supported to engage in activities in line with their preferences. Residents' safety was promoted. Residents were supported to make choices in their daily lives. However, improvement was required in relation to fire safety, personal plans and supporting residents to manage their behaviour.

Residents' rights were respected in this centre. Residents were offered choices throughout the day and these choices were respected. Where required, staff used communication strategies to support resident understand information and to express these choices. Residents were supported to engage in activities that they enjoyed. These occurred within the centre and within the wider community.

Residents' health and social needs were assessed. The supports needed to meet these needs were identified. This included behaviour support plans. However, it was not clear if all behaviour support plans had been developed with the input from appropriate professionals. In addition, the residents' personal plans were not made available to them in an accessible format.

The provider had taken measures to ensure that residents were safe. Safeguarding plans were devised when required. Safeguarding was included as a standing item on team meetings. Staff were knowledgeable on the vulnerabilities of residents and what to do should a concern arise. The provider had taken measures to protect residents from the risk of fire. This included regular fire drills, the development of emergency evacuation plans and the completion of fire safety checks. However, dates had not been identified to address issues identified through these checks.

Overall, the inspector noted that residents had a good quality of life in this centre. This was due to the provision of appropriate supports to meet the needs of residents and steps taken to protect their safety.

Regulation 10: Communication

The provider had made arrangements to ensure that the residents were supported to communicate.

Residents had communication profiles that identified how they communicated their needs, wishes, likes and dislikes. It was noted that these profiles were reviewed on an annual basis and staff were knowledgeable of their content. Where required, residents had pictures to support their understanding of information and to make choices.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to engage in activities that were in line with their interests.

A review of daily notes and weekly schedules found that residents were supported to engage in activities within the centre and in the wider community. Residents were supported to maintain contact with family and friends. Residents attended community groups and religious events with the support of staff.

Judgment: Compliant

Regulation 18: Food and nutrition

The residents had access to wholesome and nutritious food in line with their needs.

A review of the residents' weekly meetings for the four weeks prior to the inspection found that residents were offered choices at mealtimes and supported to make choices in relation to the weekly grocery shopping. Residents' notes identified that they were supported to go out to dinner and for coffee. Residents were encouraged to make healthy food choices and had access to relevant healthcare professionals in relation to their nutritional needs.

Judgment: Compliant

Regulation 20: Information for residents

The provider had submitted a copy of the residents' guide as part of the application to renew the registration of the centre. This was reviewed and found to contain the information set out in the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete three actions aimed at improving governance arrangements at the centre. The provider aimed to have all actions complete by 31 October 2023. At the time of the inspection, one action had

been completed and two had commenced and were in progress.

The action that had been completed was:

- incidents were reviewed on a quarterly basis by an incident review committee.

The actions that were in progress were:

- training in incident management had been delivered to senior managers but had not been rolled out to staff in the designated centres
- the risk management policy had not yet been finalised

In this centre, the provider had systems in place to manage risks to residents.

The inspector reviewed the individual risk assessments for residents. These were found to be comprehensive and identified control measures to reduce risks. They had been reviewed recently. The person in charge also maintained a risk register for the centre. This outlined health and safety risks and service provision risks. These assessments identified control measures and were recently reviewed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had taken measures to protect residents from the risk of fire. However, improvement was required in relation to the checks of fire safety equipment.

The residents' evacuation plans were reviewed by the inspector. These gave clear guidance to staff on how to support residents to evacuate the centre in the event of an emergency. The records of the last four fire drills were reviewed. These indicated that fire drills were completed on a regular basis and they simulated different scenarios.

The provider had completed a number of checks in relation to fire safety. The provider had completed a check of fire doors on 19 July 2023 that identified that all locks, hinges and smoke seals on the centre's fire doors needed to be replaced. The person in charge reported that the hinges and handles had been replaced in the last month. However, there was no plan or definite date for the replacement of the smoke seals.

In addition, an emergency evacuation light in the hallway of the centre had been identified as broken on four weekly checks completed in the month prior to the inspection. The emergency lighting service records indicated that they were last checked by a competent external company in September 2023. This was outside of the required three monthly checks of emergency lighting. There was no plan for the

replacement or repair of the light on the day of inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The health, social and personal needs of residents were assessed and the supports required to meet those needs had been identified. However, improvement was required in order to ensure that the personal plan was available in a format that was accessible to the residents.

The inspector reviewed the residents' personal plans and care notes and found that they gave good guidance to staff on how to support residents. An annual review of the residents' personal plans had taken place in February and March 2024. This review had assessed the effectiveness of the previous year's plan and goals for personal development had been set for the following year. The resident or a family representative had taken part in these meetings. However, these personal plans had not been made available in a format that was accessible to each resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements at the centre. The provider aimed to have all actions complete by 30 June 2024. At the time of the inspection, three action had been completed and four were in progress.

The completed actions included:

- an interim head of clinical and community support had been appointed
- additional multidisciplinary team practitioners had been employed
- a critical response team was established to review the placement of residents when required

The actions that were in progress included:

- a behaviour oversight committee was re-established but the oversight procedures and structures had yet to be finalised.
- the policy on the role of psychology and interdisciplinary team working was in draft form
- the training modules on neurodiversity were being finalised and training to managers had commenced

- the access to appropriate multidisciplinary team supports was ongoing, for example, the standardised template for behaviour support plans had not yet been introduced.

In this centre, guidance had been given to staff in relation to the supports required by residents to manage their behaviour. However, it was not always clear who had developed the guidance documents and they were not laid out in an easily accessible manner for staff.

A review of a resident's file found that behaviour support plans and other guidance documents had been developed. These outlined situations that may upset residents and how staff should respond in those situations. The documents were reviewed by staff in the centre routinely. There was evidence that some of these documents had been devised by appropriate healthcare staff, for example, an occupational therapist had developed guidance in relation to sensory processing needs. However, it was not always clearly documented who had devised the resident's core behaviour support plan. Therefore, it was unclear if these plans had been devised with input from the appropriate healthcare professionals,

There were a number of restrictive practices in the centre. These were recorded on a restrictive practice log. They were reviewed with the resident at their annual review meeting.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving governance arrangements at the centre . The provider aimed to have all actions complete by 31 October 2023. At the time of the inspection, four actions had been completed and one was in progress.

The completed actions included:

- a new system was in place to improve staff awareness of the safeguarding process
- active safeguarding plans were reviewed on a quarterly basis
- a safeguarding oversight committee had been established
- the safeguarding policy had been reviewed and was available to staff

The action in progress was:

- face-to-face training in safeguarding had been commenced but not been rolled out to all staff, including the staff working in this centre.

In this centre, residents were protected from abuse.

Safeguarding issues that were identified were reported in line with the provider's policy. When required, safeguarding plans were devised and regularly reviewed. Safeguarding was a standing item on the staff meeting agenda. Intimate care plans gave very clear guidance to staff on the supports required by residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The rights of residents were respected in this centre. The inspector reviewed the minutes of the weekly meetings that were held with residents for the four weeks prior to inspection. These indicated that a member of staff met with each resident individually to offer choices in relation to their activities for the week and their meal choices. Staff spoke about how they offered choices to residents throughout the day and this was observed by the inspector during the inspection. Residents reported that staff respected their privacy and dignity. They were knowledgeable on their right to vote in an upcoming election.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Orchard Grove Residential Service OSV-0001756

Inspection ID: MON-0043016

Date of inspection: 24/04/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has restructured the Senior Management team to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management, and oversight. Under the remit of the HSE's Service Improvement Team the Models of Service sub-group has been merged as part of the Quality, Safety and Service Improvement workstream. The Provider has revised the unannounced visit template and unannounced visits are scheduled up to 31/7/2024. The next bi-annual thematic governance and quality improvement report will be presented to the Board at the end of July. A learning management system pilot has commenced in two service areas for staff training and development and aims to implement the system to the rest of the organisation by the end of the year. The provider continues to facilitate monthly staff regulatory events. The quarterly properties and facilities plan is presented at senior management for oversight with regard to its monitoring and implementation. An organisational report is submitted to the provider from the senior management team through the Chief Executive Officer every 2 months. The provider has submitted a business case to the commissioner of services to strengthen the current on-call arrangement. An interim arrangement is being developed with Front Line Manager through the Area Teams agree an on-call system by the 30.06.2024	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The incident and monitoring committee continue to meet on a quarterly basis to monitor	

and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports.

The training module on the revised incident management policy commenced on the 15/05/2024, and further dates are scheduled for 10/06/2024, 20/06/2024 and the 24/06/2024.

The draft Risk Management Framework is in the process of stakeholder feedback. Following consultation, a draft risk management framework and training module will be presented to the Senior Management Team on the week of the 17/06/2024.

The pilot project will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Annual Fire door inspection took place on the 16/05/24, from this all fire doors and seals are up to standard from inspection. Emergency evacuation light in the centre's hallway replaced and fixed on the 25/4/24. Emergency lightening service completed on the 25/4/24

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:
The Persons Individual Plan will be available in Accessible format tailored to the persons understanding- 30/06/2024

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Governance and Clinical oversight Group has been renamed as the Critical Response Team and meets on a quarterly basis. The Neurodiversity training module has commenced with refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and the Listening and Responding Policy has been reviewed and will be considered by key stakeholders prior to implementation. The Inter Clinical Team Working Policy will be completed by the 30/06/2024.

An internal referral is completed to request input from Behaviour Support Specialist, to complete the annual review of the Behaviour Support Plan for the resident.
Review of BSP will be completed with BSS input – 30/06/2024

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff will complete face-to-face training in safeguarding. - 30/06/2024

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2024
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	30/06/2024
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	26/04/2024

	maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	26/04/2024
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/06/2024
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.	Substantially Compliant	Yellow	30/06/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/06/2024