# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

| Name of designated centre: | Seanna Cill |
|---|---|
| Name of provider: | St Michael's House |
| Address of centre: | Dublin 5 |
| Type of inspection: | Unannounced |
| Date of inspection: | 10 May 2023 |
| Centre ID: | OSV-0002356 |
| Fieldwork ID: | MON-0037935 |

## About the designated centre

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

Seanna Cill is a designated centre operated by St. Michael's House. The centre is located in Dublin and provides accommodation to a maximum of six male and female adult residents with intellectual and physical disabilities. The service caters for a broad range of needs, including, low to high support needs, behaviour support, medical needs and emotional and environmental needs. The centre comprises of a two storey, six bedroom semi-detached house. It is located close to local amenities such as shops, cafes and recreational facilities in a suburb of Dublin. Each resident has their own bedroom and share communal spaces such as sitting rooms, kitchen and dining areas and bath and shower rooms. Social care staff are on duty both day and night to support residents who live in this centre.

**The following information outlines some additional data on this centre.**

| Number of residents on the date of inspection: | 5 |
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## 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 10 May 2023 | 10:00hrs to 18:00hrs | Jennifer Deasy | Lead |
| Wednesday 10 May 2023 | 10:00hrs to 18:00hrs | Nan Savage | Support |

## What residents told us and what inspectors observed

This was an unannounced inspection of the designated centre which was scheduled to monitor ongoing regulatory compliance. Inspectors met with the five residents who lived in the service and some of the residents communicated with inspectors about their lives there. The inspectors used conversations with residents and staff, observations of residents' interactions with staff, observations of care and of the facilities, and a review of documentation to inform their judgments on the quality of service in the designated centre.

The inspectors were greeted on their arrival by a staff member. They were informed that three of the residents had left for day service and that two other residents were being supported with their morning routine. There was one residential vacancy in the centre at the time of inspection. Later in the day, the residents returned from day service and chatted to inspectors about their day.

Staff on duty made contact with the person in charge who attended the centre to support the inspection. A service manager also later attended the centre.

Staff showed the inspectors around the designated centre and informed them of the care needs and preferences of residents. Staff were seen to be familiar with residents and were well-informed regarding their care needs, and in particular, their behaviour support needs. A resident told inspectors that staff were very supportive during the bereavement of a loved one and checked in with the resident especially during significant milestones.

However, the inspectors saw that the centre was in need of comprehensive maintenance upgrades and deep cleaning. There were a number of premises issues which were impeding effective infection prevention and control (IPC) practices. For example, inspectors saw that sections of the flooring in the bathrooms and shower room were damaged and could not be effectively cleaned. Parts of the walls were damaged and dirty throughout the centre. Communal facilities within the centre also required maintenance. For instance, a number of kitchen units were worn or damaged and therefore could not be cleaned effectively. The provider had been made aware of these issues through their own internal audit system and a schedule of works had been drawn up. This will be discussed further in the next two sections of this report.

The inspectors saw that some residents' bedrooms required improved storage arrangements to ensure that their personal care items could be stored discreetly. For example, residents' incontinence wear and PPE was observed stored on shelves in one resident's bedroom.

Inspectors saw that one of the resident's bedrooms had been redecorated to the resident's preferences. The resident indicated that they liked their bedroom and were surrounded by items that were important to them. Another resident showed

inspectors their favourite possessions in their bedroom and mentioned that their bedroom was going to be redecorated which included replacing the flooring which was partly defective.

The inspectors were informed by staff that some residents in the house did not always get on very well with each other. When this occurred, staff intervened to de-escalate incidents between residents. Additionally, the inspectors were informed that one resident in the house presented with complex behaviour support needs. Inspectors were told by some residents and staff that these complex behaviour support needs were impacting on the well-being of other residents in the house at times.

In line with the registered floor plans two sitting rooms were available in the centre. However, this inspection found that the second sitting room was being provided for the sole use of one resident. This meant that the other four residents shared one sitting room and a kitchen/dining area. Therefore, while the centre could provide residents with a choice of communal spaces to spend time in, residents were restricted from accessing all areas of their home. Inspectors observed the impact of this during the inspection whereby residents opted to meet with inspectors in their bedroom space or the communal sitting room. However, in meeting in the communal sitting room there were regular interruptions as staff and residents needed to pass through this room in order to access the kitchen. One resident appeared frustrated with the interruptions and remarked to staff that they were trying to have a private conversation.

Some of the residents spoke to the inspectors regarding their experiences of living in the centre. Residents described listening to other residents shouting and engaging in behaviours that challenge. One resident described how the loud vocalisations from a peer could go on for long periods of time. This resident mentioned that they wore headphones to reduce the noise but that they could still hear the noise. The resident also mentioned how they could hear the fire doors being locked and the locks rattling when a peer was engaging in behaviours that challenge. The resident informed inspectors that they had brought their concern about the noise to the attention of the person in charge and staff. During the course of the inspection, inspectors also heard loud vocalisations in the house.

Inspectors saw that staff and resident interactions were kind and caring. However, it was noted that staff occasionally had to intervene in conversations between residents in order to de-escalate potential disagreements.

Overall, this inspection found that the provider was supporting and managing the complex needs of one resident in the centre well, however, it was not demonstrated that the provider was assessing the impact of these arrangements on the other residents who lived in the designated centre.

## Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspectors found that improvements were required to the oversight arrangements for the centre. The inspectors were not assured that the provider had put in place suitable systems and structures to ensure that all residents in the centre were in receipt of a quality and safe service which was upholding their human rights.

The provider's statement of purpose set out that a wide and varying range of needs could be supported in the designated centre. This wide scope resulted in a mix of residents with different ages, interests, abilities and needs. The current layout and design of the centre was not meeting such a wide range of assessed needs. This resulted in peer compatibility issues and practices which were impacting on residents' rights in the centre.

The provider had in place a series of audits such as six-monthly unannounced visits and an annual review of the quality and safety of care of the service. These audits were carried out regularly and documented the requirement for upgrading and maintenance of the premises and associated IPC risks.

On foot of these audits, actions had been identified and referrals had been sent to the responsible person at the provider level. However, the provider -led audits did not reflect the risks that inspectors observed in the areas of restrictive practices and their impact on residents' rights. This required improvement to ensure audits carried out by the provider were comprehensive in scope and captured all areas of quality and safety relevant to the service and the needs of the resident group.

The arrangements for monitoring and reviewing restrictive practices required improvement. A restrictive practices log was maintained however it was not demonstrated that the impact of the implementation of environmental restrictions on all residents living in the centre had been fully evaluated or assessed.

Restrictive practices, such as locking doors, when implemented, resulted in a number of residents not being able to freely access all areas of their home at all times. While the restrictive practices were reviewed regularly by the provider's monitoring committee, the inspectors saw that some practices had been in place for a long period of time without suitable evidence that alternative options were being trialled to ensure that the least restrictive practice for the shortest duration was being used. Additionally, one of the restrictive practices posed a risk to the safe evacuation of residents in the centre. This risk had not been identified by the provider through their own audits.

The inspectors saw that families and residents were consulted as part of the annual review and that they were complementary of the standard of care being provided. Family members, in particular, commented that they felt their loved ones were well cared for and that there was good communication from staff to families. Two residents spoken with on the day of inspection stated that while they were happy with the staff and the food in the centre, they were not happy with some aspects of

the living arrangements.

The centre was operating with one full-time staff vacancy at the time of inspection. This was filled by a panel of regular relief and agency staff. The inspectors were told that there was quite a stable staff team in place with many of the staff having worked in the centre for a number of several years. This supported continuity of care for residents. There was also evidence of an ongoing training and development plan for staff.

## Regulation 15: Staffing

A planned and actual roster was maintained for the designated centre.

The centre was operating with one vacancy at the time of inspection. The inspectors saw that gaps in the roster were filled by a small panel of relief and agency staff. This was supporting continuity of care for residents.

The Schedule 2 files were not reviewed as part of this inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff who worked in the centre had received training in key areas including safeguarding, manual handling and infection prevention and control. Staff were up to date with fire safety training except for one staff member who was due to complete refresher training in fire safety in March 2023. The person in charge showed inspectors confirmation that his had been followed up with the staff member.

Adequate supervision arrangements were in place. The person in charge met regularly with staff and discussed areas including key working role, support plans and continuous professional development.

Judgment: Compliant

## Regulation 23: Governance and management

The oversight arrangements for the designated centre were not effective in identifying and responding to risks that were impacting on the quality and safety of care. Provider level audits were ineffective in identifying risks in areas such as fire,

restrictive practices and human rights.

The centre's restrictive practices log detailed that the restrictive practices required to support one resident's assessed needs were not impacting on other residents. However, the inspectors saw evidence and were told that these practices impacted on residents' right to freely access all parts of their home. It was not evidenced that the provider had adequately assessed the impact of these restrictive practices on the rights of all residents.

Further assurances were also required to ensure that the least restrictive practice for the shortest duration was in place. While restrictive practices were reviewed by the provider's monitoring committee, the inspectors were informed that some practices had been in place for several years without evidence that they were the least restrictive for the shortest duration.

Local audits were not effectively capturing all risks. For example, regular fire safety audits detailed that no exits were blocked. However, the inspectors saw that one fire door from the kitchen was obstructed by a couch. The fire evacuation plan also did not provide detail on the measures to be followed should there be a fire when the fire doors were locked.

Judgment: Not compliant

## Regulation 3: Statement of purpose

Inspectors reviewed the statement of purpose on inspection. It was found that the statement of purpose required review to ensure it accurately set out the service provided in the centre.

The designated centre was registered for six beds and there were five residents living there at the time of inspection. Inspectors were informed and were shown documentation from the provider that they did not intend to fill the vacant bed. Inspectors were told that this was due to the assessed needs of one resident. The statement of purpose had not been updated to reflect this information.

Additionally, there had been changes to the function of some of the rooms of the designated centre. The statement of purpose had not been updated to reflect these changes.

Judgment: Substantially compliant

## **Quality and safety**

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspectors found that there were enhancements required to ensure that residents were in receipt of quality care that was being delivered in a safe environment.

The inspectors saw that families spoke in a complementary manner regarding the care in the designated centre and that residents also described the staff as being helpful and supportive. However, there were improvements required in the areas of restrictive practice management, fire safety and premises. Inspectors saw that the centre was poorly maintained and required refurbishment works in a number of areas. For example, floors, kitchen and utility fittings and painting throughout. The centre also required enhanced general and deep cleaning to ensure the optimum infection control arrangements were in place.

The inspectors saw that there were restrictive practices implemented in the home as part of the behaviour support arrangements for a resident with complex needs. For example, one set of fire doors situated at the front of the home had two locking mechanisms installed. These were used to lock the doors and compartmentalise part of the building when a resident was engaging in behaviour that was challenging.

While this environmental restrictive practice appeared to be effective in mitigating against safeguarding incidents, it was impacting on the other residents’ right to freely access the entirety of their home including being able to access their front door. When this restrictive practice was being implemented, residents entered and exited the building through a back door and side gate. There was no documented information that detailed the impact of the current living arrangements and restrictive practices on all of the residents' quality of life.

The centre's restrictive practices log detailed that restrictive practices were not impacting on other residents. However, inspectors saw that residents did not have full access to their home, including their second sitting room due to the assessed needs and restrictive practices required to support one resident.

Two residents spoke to inspectors regarding their dissatisfaction with the current living arrangements. Residents spoke about the negative impact on their well-being from listening to incidents of behaviours that challenge in the house. One resident said that they had previously made a complaint about the noise and had been provided with headphones however, these were ineffective.

The inspectors found that the fire evacuation arrangements required review. Inspectors were not assured that all residents could be evacuated safely.

One set of corridor fire doors were regularly locked as part of an environmental restrictive practice arrangement for the management of behaviours that challenge. The main fire exit, which was the only exit with a thumb lock, was accessed through these fire doors. The centre's evacuation plan did not provide information on how the residents should evacuate when this restrictive practice was in place. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk.

The inspectors also saw that all other emergency exits required a key in order to evacuate and were not thumb locks. While keys were located in break glass boxes beside these exits, it was noted that the arrangement could potentially impede a safe evacuation of the centre and had not been adequately risk assessed

There was limited availability of private space in the centre. This was impacting on residents' ability to receive visitors and to have private conversations. One resident required sole use of a second sitting room. This meant that four other residents shared one living room and a kitchen/dining room. The living room available for use by the majority of residents was also not a quiet or separate private space as, in order to access the kitchen, residents and staff had to pass through this living room.

Overall, inspectors found that, due to the assessed needs of one resident, there were long-standing restrictive practices in the centre which were impacting on other residents' rights. While the residents were being supported by a competent staff team and the restrictive practices were being generally effective in mitigating against the occurrence of safeguarding incidents, the living arrangements were not upholding all residents' rights or contributing to a long-term homely environment.

## Regulation 11: Visits

Residents did not have access to a suitable private area to receive visitors. Residents spoke about the impact of not having an additional private living space. Inspectors saw that it was difficult for residents to have private conversations and that residents sought to have these conversations in their bedrooms.

Judgment: Not compliant

## Regulation 17: Premises

Parts of the premises was seen to be very worn and in a poor state of repair both internally and externally. Some areas were also not maintained to a good standard of cleanliness.

- painting was required throughout the designated centre. Walls and ceilings were seen to be damaged, dirty and had paint flaking off
- bathroom floors required replacement, and in the interim, deep cleaning
- sections of the bathroom and shower room floors and wall grouting were seen to be damaged and badly stained.
- bathroom mirrors were damaged and required replacement
- some bathroom tiles were cracked and there was mildew noted in the main bathroom
- kitchen and utility units were damaged and could not be effectively cleaned

- toilets required deep cleaning as some toilet bowls were seen to be very stained
- the garden was not properly maintained. Grass was very overgrown and sections of the pavements were covered with weeds.
- Storage of personal items in residents' bedrooms required review to ensure these were stored in a manner that best supported residents' dignity and autonomy. Toiletries were seen stored in one sink. Personal hygiene items were stored openly on a shelf.

The layout of the centre did not meet the aims and objectives of the service and the needs of all residents. This inspection found a proportion of the designated centre was being used by one resident alone which other residents could not access. The impact of this on the other residents had not been considered.

This second living room had been previously designated as a quiet room space for use by all residents. However, it was not available to all residents living in the centre as it was required for the sole use of one resident.

A vacant bedroom space was being used for a different purpose than set out in the statement of purpose.

Judgment: Not compliant

## Regulation 18: Food and nutrition

Residents' food and nutritional needs were assessed and systems were in place to monitor residents' nutritional intake. Staff had received relevant training in this area.

A variety of food was available to residents and choices were offered to residents at mealtimes. Inspectors had the opportunity to observe some mealtime experiences for residents.

Residents were encouraged and appropriately supported to prepare their own meals and appeared relaxed at these times.

Judgment: Compliant

## Regulation 27: Protection against infection

Premises issues were presenting a risk of transmission of infection in the designated centre. These risks had been identified in the provider's own six monthly audits and an IPC audit completed in October 2022.

The inspectors saw that a comprehensive action plan had been derived from the

provider's IPC audit. Some of these actions had been completed. For example, the ceiling in one bathroom had been repaired. However, other maintenance issues were hindering the staffs' ability to adequately clean and maintain the centre in a manner that best reduced the risk of transmission of infection.

The inspectors saw that the hand wash arrangements in the kitchen required review. The paper towels were stored over chopping boards meaning that staff had to reach across chopping boards with wet hands in order to dry their hands. The bin to dispose of paper towels was located some distance away. These issues presented a risk of transmission of infection and were impeding effective hand hygiene procedures.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

The inspectors found that the fire evacuation arrangements required review. Inspectors were not assured that all residents could be evacuated safely.

One set of corridor fire doors were regularly locked as part of an environmental restrictive practice arrangement for the management of behaviours that challenge. The main fire exit, which was the only exit with a thumb lock was accessed through these fire doors. The centre's evacuation plan did not provide information on how the residents should evacuate when this restrictive practice was in place. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk had been reviewed and that the fire evacuation plan had been updated. However, it was not demonstrated that a review of the practice of locking compartmentalising fire doors had been carried out to examine the risk presented by the implementation of this practice and if suitable and more effective alternatives could be put in place.

The inspectors saw that all other emergency exits required a key in order to evacuate and were not thumb locks. While keys were located in break glass boxes beside these exits, it was noted that the arrangement could potentially impede a safe evacuation of the centre and had not been adequately risk assessed

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

A sample of residents' files were reviewed by the inspectors. The inspectors saw that residents had an up-to-date assessment of need. The assessment of need was used to inform care plans which were written in person-centred language.

Judgment: Compliant

## Regulation 7: Positive behavioural support

There were a number of restrictive practices in place in the designated centre. While these had been approved by the provider's rights committee, it was not evident that they had been implemented for the shortest duration possible or that the least restrictive practice was being used.

For example, one resident did not have access to specific cutlery during their meals. Staff instead cut the resident's food up for them. This practice was reported to be in place for several years due to a previous risk related incident.

However, inspectors saw that this resident had ready access to this type of cutlery within the kitchen when preparing meals. It was therefore not evidenced that this restrictive practice was proportionate or warranted. Equally it was not demonstrated that less restrictive practices had been trialled with the resident.

A training need in positive behaviour support was also identified. Approximately 50% of staff were awaiting in-person behaviour support refresher training at the time of the inspection.

Judgment: Not compliant

## Regulation 9: Residents' rights

Restrictive practices in the centre were impacting on the rights of all residents. The inspectors saw that on 11 occasions in 2022, the double fire doors in the centre leading to the front of the house had been locked for times ranging from 11 minutes to two hours and 30 minutes. This was due to the behaviour support needs of one resident. While these doors were locked, residents would not have been able to access their front door or the staff offices. During these times, residents were required to come and go from the centre using the back door and side passage if they were leaving the centre.

The impact of this restrictive practice on residents' rights had not been assessed. The centre's restrictive practices log detailed that restrictive practices had no impact on other residents.

Residents described their experience of the living arrangements to inspectors. Residents said that they were not happy and had told the person in charge and staff this. It was not demonstrated residents had been supported to access advocacy services to support them in addressing their dissatisfaction.

The inspectors saw that residents' belongings, and in particular, their personal care items were not always stored in a discrete manner to ensure residents' privacy and dignity arrangements.

Residents had rights care plans on file however they did not include information on the living arrangements or peer compatibility.

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 | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Not compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Seanna Cill OSV-0002356

## Inspection ID: MON-0037935

## Date of inspection: 10/05/2023

**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 | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider will carry out a review of all restrictive practices and the impact these restrictions have on the rights off all Residents.
Following this review all Residents Assessments of needs and relevant support plans will be updated.
An action plan will be devised following assessment of all Residents.

The Policy on Restrictive practices in currently under review. The 6 monthly audit tool will be reviewed to reflect any changes in the policy.

The Person in Charge has moved the couch back to its original position to address the fire safety concerns identified by the inspector on the day of inspection.

Local audits will be reviewed to ensure all potential risks will be identified and escalated appropriately.

| Regulation Heading | Judgment |
|---|---|
| Regulation 3: Statement of purpose | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The provider will review the Statement of Purpose for the designated centre to reflect the number of Residents living in the centre and the provider will update the Statement of purpose to reflect the correct function of all rooms in the designated centre.

| Regulation 11: Visits | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 11: Visits:
The provider will carry out a review of the current visiting arrangements with residents and their families. Arrangements will be made to provide a private space for residents to meet their families (if required).

| Regulation 17: Premises | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider has an agreed schedule of works for all necessary upgrades to the premises. The required work is scheduled and will be carried out by 30/09/23.

- A deep clean of the centre was completed on the 10.07.2023
- PIC emailed TSD on 11.05.2023 for grass to be cut and weeds sprayed – this was completed in interim
- Personal Hygiene items have been placed into a press in residents' room on 24.05.2023
- Resident and staff have been informed to keep sink area free from items on 24.05.2023

| Regulation 27: Protection against infection | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
PIC Moved chopping boards to no longer be near the sink on 14.05.2023

Resident and staff have been informed to keep sink area free from items on 24.05.2023. Residents exercise an element of personal choice and staff will continue to remind residents to not store items in the sink.

| | |
|---|---|
| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
- PIC updated house fire evacuation plan per urgent action requirement by 15.05.2023, which was submitted and accepted by The Authority.
- The centre is listed to have thumb locks put on each exit per Organisational upgrade works 31/08/2023
- Break glass units remain in place with necessary keys at every fire exit in the event of emergency
- The couch has been moved from one of the fire doors from the kitchen on the 24.05.2023
- On the 03.07.2023 there was a key pad and emergency unlock push system put into place at both sides of the middle doors in the centre replacing the turn key system. This was reflected on the house evacuation plan 03.07.2023

| | |
|---|---|
| Regulation 7: Positive behavioural support | Not Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
PIC emailed training department to confirm training dates for face-to-face element of PBS training.

PIC has linked with H&S manager and clinical psychologist who knows the residents well, to agree and implement the best practice for reducing a restrictive practice in place for one resident. A draft PBS plan is in place and an updated restrictive practice arrangements are being finalised. This will be reviewed as part of regulation 5 review of the resident.

The provider will carry out an independent review of all restrictive practices in the designated centre ensuring the least restrictive practice is in place for the shortest duration possible.
An action plan will be devised following this review.
The Policy on Restrictive practices in currently under review.

| | |
|---|---|
| Regulation 9: Residents' rights | Not Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The provider will carry out an independant review of all restrictive practices and the impact these restrictions have on the rights of all Residents. Following this review all Residents Assessments of needs and relevant support plans will be updated.
An action plan will be devised following assessment of all Residents.

The provider will ensure that residents are provided with additional information to access external advocacy should they choose to do so. This was completed on 09.07.2023 and residents have access to this in easy to read format booklet in the centre from the National Advocacy Service For People With Disabilities. Staff will discuss the area of advocacy regularly within the residents weekly house meetings

The registered provider carried out a 6 monthly audit immediately following the inspection. The provider consulted with residents as part of the audit.

The PIC has arranged rights training for the staff team scheduled for July and August 2023

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
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| Regulation 11(3)(b) | The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident's room, is available to a resident in which to receive a visitor if required. | Not Compliant | Orange | 06/02/2024 |
| 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 | 30/09/2023 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre | Not Compliant | Orange | 30/09/2023 |

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| | 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 | 30/09/2023 |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Not Compliant | Orange | 30/09/2023 |
| 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 | 31/10/2023 |
| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and | Substantially Compliant | Yellow | 30/11/2023 |

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| | quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. | | | |
| Regulation 27 | The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. | Substantially Compliant | Yellow | 30/05/2023 |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Not Compliant | Red | 31/08/2023 |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 31/08/2023 |
| Regulation 07(2) | The person in charge shall ensure that staff | Substantially Compliant | Yellow | 24/12/2023 |

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| | receive training in the management of behaviour that is challenging including de-escalation and intervention techniques. | | | |
| Regulation 07(5)(b) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used. | Not Compliant | Orange | 30/11/2023 |
| Regulation 07(5)(c) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used. | Not Compliant | Orange | 30/11/2023 |
| Regulation 09(2)(d) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights. | Not Compliant | Orange | 09/07/2023 |
| Regulation 09(2)(e) | The registered provider shall ensure that each | Substantially Compliant | Yellow | 09/07/2023 |

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| | resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre. | | | |
| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | Not Compliant | Orange | 31/10/2023 |