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:	Royal Oak
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	14 July 2022
Centre ID:	OSV-0002361
Fieldwork ID:	MON-0035997

About the designated centre

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

Royal Oak is a designated centre based in a North Dublin suburban area and is operated by St Michael's House. It provides community residential services to three male residents with intellectual disabilities over the age of 18. The designated centre is comprised of two attached houses with an internal door for access. The designated centre consists of five bedrooms, two kitchen come dining rooms, two sitting rooms, an office, two bathrooms and two toilets. There was a garden to the rear of the centre which contained two small buildings which were used for laundry and storage. The centre is located close to amenities such as shops, cafes and public transport. The centre is staffed by a person in charge and social care workers. Staff have access to nursing support through a nurse on call service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 14 July 2022	09:25hrs to 17:30hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which was scheduled to monitor ongoing regulatory compliance in the designated centre. The designated centre was last inspected in January 2022. High levels of non-compliance were identified on that inspection and a cautionary meeting was subsequently held with the provider. The provider submitted a comprehensive action plan which detailed measures that they would take to come into compliance. The inspector saw, on this inspection, that while the provider had addressed some of the issues identified, such as the maintenance of the premises, there remained significant levels of regulatory non-compliance which were impacting on the quality and safety of care provided to the residents.

The inspector had the opportunity to meet all three residents on the day of inspection. The inspector used conversations with residents and key staff as well as a review of the documentation to form judgments on the quality and safety of care in the service. The inspector wore a face mask and maintained physical distancing as much as possible during all interactions with residents and staff.

The inspector was greeted by a resident and a staff member on arrival to the centre. The resident expressed that they were pleased to see the inspector and were eager to show her the new kitchen and painting that had been completed. The inspector saw that staff were wearing a disposable face mask when they answered the door however there were no facilities for hand sanitising on arrival. The inspector was not asked to sanitise her hands and there were no COVID-19 symptom checks completed.

The inspector was informed that the new person in charge was on unexpected leave. The staff stated that they would contact the provider's head office in order to determine who the on-call service manager was. The staff were observed making and responding to numerous phone calls throughout the morning in this regard. It was approximately one and a half hours before it was determined what the oversight arrangements for the day were.

While the staff were taking calls, the resident showed the inspector around the houses. The inspector saw that each house had been fitted with a new kitchen. New dining tables and chairs were also in each kitchen and one of the sitting rooms had been furnished with new sofas and armchairs. The resident told the inspector that they had been involved in choosing the new furniture and that they were pleased with it.

The resident also showed the inspector their bedroom. They told the inspector that their bedroom had been recently painted, that they had chosen the colour and were happy with it.

The inspector saw that external and internal walls in common areas had also been

freshly painted. Maintenance had been completed to the utility room and in the garden.

During the walk around of the centre, the inspector saw several infection prevention and control (IPC) risks. These included a lack of hand washing facilities and soiled toilets. This will be discussed further in the quality and safety section of the report.

One resident told the inspector that they were getting ready to go to their day service and would be going on a boat trip. They also showed the inspector certificates from recent courses that they had completed and photographs of trips to community activities such as the circus.

The inspector met another resident who had requested support from a particular staff member with their personal care. The inspector saw that staff responded to this resident's requests in a respectful manner. This resident was not attending day service on the day of inspection. The inspector was informed that day service was temporarily closed due to cases of COVID-19. Staff supported this resident to engage in their preferred activities in the community during the day, and later to watch television.

The inspector briefly met the last resident on their return from work. This resident greeted the inspector and told her that they had been busy in work. The resident chose not to engage with the inspector any further.

Staff spoken with were aware of residents' needs and were endeavouring to provide support in line with these needs. However, staff reported that due to staffing vacancies, it was difficult to meet all of residents needs as per their care plans. The inspector saw staff discussing the upcoming roster and changes that were required due to the unexpected absence of one staff. It was evident that there were resourcing issues which were impacting on the quality of care in the designated centre. This will be discussed further in the capacity and capability of the report.

Overall, the inspector saw that staff were attempting to meet the assessed needs of residents and that residents were comfortable in their home. However, staff shortages and gaps in the management structure were impacting on the quality of care and were presenting risks to the health and wellbeing of the residents who lived in this designated centre.

Capacity and capability

This inspection was an unannounced inspection, the purpose of which was to monitor the progress the provider was making in coming into compliance with the Regulations. 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 inspector found that the provider had failed to enhance their oversight mechanisms of the designated centre in a manner required in order to bring the centre into regulatory compliance.

There had been numerous changes to the management structure since the inspection in January 2022, including two changes to the person in charge role and a vacant director of services position. This resulted in a lack of clarity regarding the chain of command, as evidenced by the length of time it took on the morning of inspection to identify who was responsible for the oversight of the centre on that day.

The service manager had been nominated to fill the person in charge role on an interim basis. While the service manager had the necessary qualifications and experience to fulfill the regulatory requirements of a person in charge, they had additional duties and were not present in the centre on a regular basis in order to provide oversight.

The inspector saw that some of the person in charge duties had been allocated to the full time staff. These included completing local audits. However these staff, when spoken with, were unaware of their remit of their responsibilities and did not have access to protected time in order to do so.

The centre was operating with several vacancies at the time of inspection. The staff reported that they did not have sufficient time to carry out all of their responsibilities due to the resourcing issues and the complex assessed needs of the residents.

The inspector saw that the provider was using a small panel of relief staff to fill gaps in the roster. However, the contingency arrangements were insufficient to meet the needs of the residents. The inspector saw that staff had to plan how to fill upcoming gaps in the roster due to the unexpected leave of one staff member. Staff were willing to take on additional shifts in order to support continuity care of residents although they acknowledged to the inspector that this was difficult and was not sustainable.

There was poor communication from the provider to staff in relation to the actions required to enhance the quality and safety of care in the service. Staff were uninformed regarding changes to the provider's policies and action plans arising from provider led audits.

A review of the centre’s accidents and incidents log demonstrated that most incidents were reported to the Chief Inspector as required by the regulations. However, the inspector saw on resident files that body checks had identified minor injuries which had not been notified. These were required to be notified on a quarterly basis to the Chief Inspector.

The inspector also reviewed the provider’s complaints log and saw that one resident had made a recent complaint which was recorded as having been resolved to the satisfaction of the complainant. However, it was not evidenced that the resident had received the information as requested in their complaint or that the provider had followed up in order to keep the resident informed regarding the outcome of their

complaint.

Generally, the inspector saw that staff were attempting to provide care to residents which was in line with their assessed needs, however due to poor oversight arrangements and resourcing issues, staff were unable to provide care in a manner that was in line with best practice and that ensured a safe and quality service was being delivered. There were ineffective mechanisms to ensure oversight of the designated centre and to ensure that actions required to ensure that residents were in receipt of good quality care were progressed.

Regulation 15: Staffing

The centre was operating with 1.5 whole time equivalent vacancies (WTE) at the time of inspection. Gaps in the roster were being filled by a small panel of regular agency staff and by relief hours provided by the permanent in-house staff. This was somewhat supporting continuity of care for residents. However, the lack of a full permanent staff team was seen to be impacting on residents' well-being. Residents' assessments of need detailed the importance of familiar staff in supporting them in order to manage anxiety and behaviours that challenge. It was documented that the changes to the staffing arrangements over recent months had contributed to a number of incidences of behaviours that challenge in the centre.

A roster review had recently identified that the staffing whole time equivalent allocation required increasing. This had not been implemented at the time of the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems were ineffective in ensuring that the service was safe, appropriate to meet residents' needs and consistently and effectively monitored. There had been several changes to the management structure of the designated centre. It was evident that the current arrangements were not effective in progressing the required actions in order to bring the centre into regulatory compliance. Actions arising from audits had not been progressed and, aside from premises works, actions from the provider's previous compliance plan also remained outstanding.

The day to day oversight arrangements for the centre were insufficient. There was a lack of clarity on the morning of inspection regarding who was responsible for oversight of the centre on that day. It took several phone calls over the course of 90 minutes to establish the chain of command.

The person in charge was not available to the centre to be on site on a frequent basis. Staff had been allocated additional responsibilities in the absence of an on-site person in charge. For example, staff had been tasked with completing monthly audits of resident finances and of health and safety. Staff spoken with were unfamiliar with their assigned duties. They had not received training in this regard and did not have access to protected time in order to complete these duties. It was clear that local audits were not taking place as required. The person in charge was unaware that these audits were not being completed.

There was poor communication from the provider to staff in relation to policy updates and required actions to ensure a safe service was being delivered to residents. Staff meetings, while scheduled monthly, did not always take place. There were no records of staff meetings in April or May 2022. Action plans were not derived from staff meetings in spite of actions being identified.

Important changes to provider's policies and the findings and required actions of recent audits were not discussed at meetings. Staff were uninformed regarding these when asked by the inspector. This resulted in staff engaging in practices which posed a risk to health and wellbeing of residents. For example, staff were handling soiled linen in a manner which presented a risk of transmission of infection. It was therefore not evidenced that staff were supported and performance managed to exercise their responsibility for the quality and safety of services they were delivering.

While provider level audits were completed, the actions arising from these were not progressed in a timely manner. For example, several risks relating to IPC were identified in an audit in May 2022. The majority of these risks remained outstanding on the day of inspection. The provider's most recent six monthly audit had also identified actions which were not progressed

The contingency arrangements to ensure that cover could be provided were insufficient. Staff were seen on the day of inspection attempting to cover upcoming gaps in the roster due to unexpected leave being taken. Staff did not escalate the proposed changes to the roster through the management chain and there was no plan in place in order for staff to source additional agency staff. Staff reported that they were taking on additional shifts and that it was difficult at times to cover the roster in a way that met the needs of all residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of documentation found that most incidents were reported to the Chief Inspector as required by the Regulations. However, the inspector saw on resident files that minor injuries had been recorded but had not been notified to the Chief

Inspector on a quarterly basis as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had effected a complaints procedure for residents which was accessible. The inspector saw that resident complaints were recorded and were responded to in a timely manner. However, it was not evidenced that residents' complaints were effectively resolved before being closed.

For example, the inspector saw that one resident had recently made a complaint regarding the length of time that they were waiting to receive an independent living placement. They requested an update as to their status on the housing list. The resident was informed that the person in charge would follow up on this and their complaint was then closed. There was no evidence that the resident received the information that they had originally requested as per their complaint.

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 inspector found that, while the provider had addressed premises related issues identified on the last inspection, there remained a high level of non-compliance. In particular, enhancements were required to the IPC practices in the centre and to ensure that peer compatibility and rights based issues were responded to in a timely manner.

The inspector saw that the provider had completed premises works as described in their compliance plan subsequent to the last inspection. The premises was seen to be well-maintained. New kitchens and furniture had been purchased and walls had been painted throughout. Residents had access to sufficient communal and private spaces and had facilities to cook, manage their laundry and store their personal belongings.

The inspector saw on a walk-through of the premises that there were a significant number of infection prevention and control risks in the centre. Many of these risks had been identified on the provider's IPC audit which was completed in May 2022. However, actions to address these risks had not been progressed. The inspector also identified additional risks which had not been captured on this audit.

A review of residents' files was completed on the day of inspection. The inspector

saw that most residents had an up-to-date assessment of need which was used to inform care plans. However, some care plans were absent from residents' files and staff were uninformed regarding other care plans including those relating to residents' communication systems.

There was a history of peer compatibility issues in the designated centre. Staff informed the inspector that one resident could be impacted by another residents' behaviours. This led to conflict and peer to peer related incidents. There had also been a number of safeguarding incidents in recent weeks which were partly attributed to staff resourcing issues. There was no risk assessment available in this regard and there was no evidence that the provider had undertaken a peer compatibility assessment or had a plan in place to respond to these issues.

One resident had expressed for a considerable length of time that they wished to live independently. This resident appeared to be managing the majority of their personal affairs without support and had completed several courses in independent living. It was referenced on the residents' file since July 2021 that an independent living assessment was to be carried out however this had not been completed by the time of inspection. The inspector was informed that the resident struggled to engage with clinical staff in this regard. The resident had not been supported to access advocacy services to support them to progress their goal.

Overall, the inspector found that significant enhancements were required to the quality and safety of this service. The inspector was not assured that residents were in receipt of a quality service or that the environment of the designated centre was safe and protected residents from known risks.

Regulation 17: Premises

The provider had taken action to address the premises issues which were identified on the previous inspection. The inspector saw that the houses had been painted both internally and externally and were generally well-maintained.

Disused furniture had been removed from the back garden.

Each house had been fitted with a new kitchen and table and chairs. Residents spoken with were happy with the renovations. Residents described how they had been involved in choosing the new furniture and paint colours.

One resident showed the inspector their bedroom and appeared proud of it. The inspector saw that the room was decorated in line with the resident's personal preferences.

The provider had made arrangements to ensure that the matters to be provided for as per Schedule 6 of the regulations were in place.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had not taken appropriate action to ensure that residents were protected from acquiring a healthcare associated infection.

An infection prevention and control (IPC) audit had been completed by the provider in May 2022. This audit identified several actions required in order to mitigate against the risk of residents acquiring a health care associated infection. The inspector saw that the majority of these actions had not been progressed.

The inspector identified additional risks on the day of inspection which were not captured in the IPC audit.

Staff were not informed regarding the provider's IPC policies. Staff were implementing practices in the management of soiled laundry which posed a risk to the transmission of infection.

IPC risks identified on the day of inspection included:

- the storage of kitchen utensils behind a handwash sink. This was identified as an action on the provider's IPC audit however it had not been addressed.
- an absence of bin liners in some bins which contained used personal protective equipment (PPE). This was also identified as a risk on the provider's IPC audit
- an absence of soap at any of the downstairs sinks in one of the houses
- a significant lack of hand sanitiser in both houses. Hand sanitiser which was available did not have an expiry date and, due to the sun bleached nature of the label, appeared that it had been in the house for some time
- disposable paper towels were not located near to the handwash sink and there was a risk of contaminating dishes when reaching for paper towels
- laundry practices which were not in line with the provider's policy and best practice. These included inadequate PPE in the handling of soiled laundry, absence of alginate bags and the sluicing of laundry in the utility sink
- hand hygiene was not observed to be completed by staff or residents on the day of inspection. The provider's IPC audit also did not see evidence of good hand hygiene practices and gave a compliance rating of 33.33% for prevention of communicable diseases.
- one downstairs toilet was heavily soiled
- the sink in one of the downstairs toilets was dirty around the taps and drain
- mould and hair was seen inside the seal of the washing machine
- flat head mops stored in the utility room were dirty. Staff were unaware of what these mops were used for
- a green mop was also soiled. Staff were unaware of what the green mop was used for
- resident files containing their assessments of need and care plans were

damaged and soiled
- damaged laminate flooring was evident throughout the house. The flooring could not be effectively cleaned. This was identified in the provider's IPC audit as requiring action

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Most of the residents' files were reviewed on the day of inspection. The inspector saw that each resident had an up-to-date assessment of need that had been recently reviewed. However, some care plans as required by the assessment of need were not available in resident files. For example, some residents' assessments of need identified that they require care plans for pain management or emotional wellbeing. These plans were not available on residents' files.

Other care plans were not dated or signed and staff spoken with were unaware of these. The inspector saw that one resident had a communication care plan which detailed the requirement for the use of social stories and a communication schedule to reduce anxiety when new or agency staff were in the centre. Staff spoken with were unaware of this care plan and had not seen these supports in use.

Judgment: Substantially compliant

Regulation 8: Protection

There was a history of peer compatibility issues in this centre. Peer compatibility was reported by residents to be an issue in the provider's annual review of service in 2021. Staff described how one resident can become upset by another resident's behaviours towards staff. This was reported by staff to have led to peer to peer safeguarding incidents. There had also been a number of safeguarding incidents in recent weeks in the designated centre which were partly attributed to staff resourcing issues and the lack of familiar staff for residents.

While the inspector saw that safeguarding incidents were recorded and reported to the relevant statutory agencies, it was not evidenced that the provider had undertaken peer compatibility assessments or had a plan in place in order to respond to peer compatibility issues. Due to resourcing issues and a lack of appropriate risk assessments, it was not evidenced that the provider had adequate measures in place to ensure that all residents were protected from all forms of abuse.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector saw that residents were supported to exercise their autonomy in managing their activities of daily living as per their assessed needs and preferences. However, one resident was limited in their ability to exercise real control over their everyday life as the provider had failed to progress their goal of independent living.

The inspector saw that this resident had expressed that it was their goal since 2016 to live independently. The provider had not progressed this goal in a timely manner. At the time of inspection, this resident was managing their own laundry, shopping, cooking, medication and finances. The resident had also engaged in further education and completed courses relating to independent living.

The provider had supported the resident to join the housing list for council housing and had committed through their compliance plan in January 2022 to complete an independent living assessment. This assessment had not been completed. The person in charge attributed this to a social work vacancy.

The inspector saw, on reviewing files, that this assessment was outstanding since at least July 2021. The resident had been informed regarding advocacy services but had not been supported to avail of these. The provider had failed to progress this residents' goal of independent living in a timely manner.

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	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Royal Oak OSV-0002361

Inspection ID: MON-0035997

Date of inspection: 14/07/2022

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: The PPIM has reviewed the staffing arrangements in the designated centre. The following actions are completed. · 1 WTE Social Care Worker vacancy has been filled and staff commenced on 1.08.22 · The Person in Charge vacancy has been filled by a suitably qualified and experienced Person in Charge. New PIC to commence in role on 30th Aug 2022. · Additional management oversight by the service manager is in place until the new person in charge commences in role.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider and service manager have completed the following actions: · New Director of Adult Services has been appointed and will commence in role from 08/08/2022 · New Person in Charge identified and start date agreed. · Additional governance & management oversight by the Service Manager implemented from 18/07/2022. · Identified lead on all shifts is now highlighted on roster in designated centre . · Shift lead oversees delegation of duties to staff on shift. · Service Manager met with frontline staff and provided a briefing on their role with regard to the auditing of their key clients finances and with oversight by PIC. PIC signs off on all residents monthly finance audits. · Service manager has provided a briefing to all staff have on their role regarding health	

and safety and the completion of hazard inspection checklist which will identify and H&S concerns.
The registered provider, Service manager and PIC will complete the following actions:
· Additional staff meeting scheduled for August 25th 2022- Action plan will be developed from this meeting.
· Updated IPC policies have been printed and are available to staff team, and all staff are required to ensure they have read and signed as understood all the changes to these policies. Member of IPC department scheduled to attend staff meeting to brief team on updated policies .25/08/2022
· Service manager has reviewed Hygiene Audit carried out in May 2022. All outstanding actions, including premise related actions, will be completed by 30/11/22.
· Service Manager will develop contingency plan to address the process of escalation in the event of staffing issues. This will be presented to staff team on 25/08/22.
· Service manager will review all outstanding actions from all audits in the DC. This is to be completed by the 30/8/2022.Service manager will develop plan to address all outstanding actions.
· PIC will provide oversight and management of all audits and related actions in the designated centre. These will be reviewed monthly by PIC & Service Manager as part of monthly Management meetings.
· Support meetings with staff completed by service manager in line with organisations supervision policy and concerns raised by staff are addressed at this stage. This duty will transfer to the newly appointed PIC when they commence in their role.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The registered provider and PPIM have completed the following actions:
· PIC has made retrospective notifications for bruising noted on body chart during inspection. 10/08/2022
· Service manager reviewed quarterly notification for quarter 2 and there were no incidents to report.
· PIC and service manager will discuss notifications in advance of due date.
· Service manager briefed all staff on the requirement to record and notify all minor injuries.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints

procedure:
· Service manager/PIC will review complaints within the centre and consult with resident to assess his satisfaction with current status of complaint.
The existing complaint is currently closed and will be reopened if resident remains dissatisfied –15/8/2022
Complaints manager will, on behalf of the registered provider, review complaints in the Designated Centre and will identify outstanding actions.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The registered provider and the service manager have reviewed this regulation and have completed/ will complete the following actions:
· Reviewed all actions from recent IPC Audit in May 2022 and outstanding actions have been identified. A local time bound plan is in place to complete these actions. As several of the actions require external contractors the plan is scheduled for completion by 30/11/22.
· All updated IPC policies are printed and available to staff. All staff signed as read and understood Information with regard to their role in IPC. Member of IPC department is attending staff meeting on 25/08/22 to brief staff on updated IPC policies.
· Area around sinks are now free from clutter. Staff are supporting residents not to put utensils behind sinks.
· Hand hygiene training scheduled for all staff on 25/8/2022.
· Key workers will review all social stories/ Online training regarding hand hygeine with residents by 30/08/22.
· All staff are fully briefed on the proper maintenance of soiled laundry and use of alginate bags where required-Alginate bags are in place and instuctions on display in laundry room-5/8/2022
· PIC will review all cleaning schedules and these will reflect evidence of IPC being maintained.
· All staff are aware of colour coding of cloths and mops regarding specific areas in the DC-Signage in place highlighting this. 05/08/22
· Replacement of damaged residents files - 5/8/2022
· The serivce manager and technical services have agreed a schedule of work to replace the laminate flooring. To be complete by 30/11/2022.

Regulation 5: Individual assessment	Substantially Compliant

and personal plan	

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The registered provider and Service Manager reviewed this regulation and have agreed the following actions:
· PIC will carry out review of AON for all residents and where specific supports identified support plans will be in place- This will be completed by 30/08/22
· All support plans will include the date of review and will be signed by the keyworker and the PIC by 15/09/22.
· Information pertaining to support documents is included in the relief folder that directs staff to this information.
· All relief staff and agency staff will sign off on handover of information.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Regulation 8: Protection
Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The following supports are in place to manage peer to peer concerns:
· All staff have received Safeguarding training.
· All staff have completed PBS training
· Incidents or peer to peer interactions are managed in line with the safeguarding policy.
· Service Manager/PIC will review all safeguarding plans and risk assessments to incorporate guidance for agency and relief staff. -30/08/22
· Meetings with residents following incidents will be implemented to assess any impact of behaviours, and any concerns identified by residents will be screened under safeguarding.
· The procedure for notifying the regulator of unexplained bruising is in place in the designated centre.
· Where resident engages in SIB this is documented and reported to the regulator in quarterly submissions.
· Compatibility assessment has been initiated and Multi Disciplinary Team have been invited to meet to review compatibility issues. Assessment scheduled to be complete by 30/09/22.

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Registered Provider and PPIM have reviewed this regulation and are committed to upholding resident's rights. · One resident has previously expressed a desire to live independently. The provider is committed to supporting this resident to achieve his goal in line with his will and preference. · Further information on supports provided to resident achieve their goal is available for inspection within centre.	

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	30/09/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/09/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	30/09/2022

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	25/08/2022
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	25/08/2022
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	Substantially Compliant	Yellow	15/08/2022

	chief inspector and shall prepare a written report on the safety and 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 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	25/08/2022
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	Not Compliant	Orange	30/11/2022

	published by the Authority.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	15/08/2022
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	15/08/2022
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	15/08/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs,	Substantially Compliant	Yellow	30/08/2022

	as assessed in accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/08/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	15/07/2022
Regulation 09(2)(b)	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 the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	05/09/2023
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	Substantially Compliant	Yellow	16/08/2022

	his or her rights.			