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:	Charnwood Gardens - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	10 May 2023
Centre ID:	OSV-0003072
Fieldwork ID:	MON-0035789

About the designated centre

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

Charnwood Gardens is a community based residential home for four adults with an intellectual disability. It is based in a suburban area of North-West County Dublin and is comprised of one house. The house is close to a number of local amenities and has good public transport links. There are five bedrooms in the premises of the centre, four of which provide individual accommodation for residents, one of which has an ensuite bathroom and one which is used for a staff sleep-over room. In addition to sleeping accommodation, there is an entrance hallway, a modest sized living room, a kitchen come dining space, a utility room, a small downstairs toilet area, a main bathroom upstairs, a garage space adjacent to the centre, a garden area to the rear with decking area and a small garden with driveway to the front of the property. The centre provides 24 hour residential supports for four residents. The staff team is comprised of a person in charge and social care workers.

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
Wednesday 10 May 2023	10:00hrs to 16:45hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

On the day of the inspection, there were three residents living in the centre. The inspector had the opportunity to meet with all residents throughout the inspection. In addition to speaking with residents, the inspector observed daily routines with residents, spent time discussing residents' specific needs and preferences with staff and completed a documentation review in relation to the care and support provided to residents. The inspector also had the opportunity to spend time with the person in charge and staff.

The inspector met with all three residents living in the centre at different times throughout the inspection. On arrival to the centre, one resident was relaxing before they had to leave the house to take a bus to their place of work. The resident spoke to the inspector about their new employment and how much they liked it and thought it suited their skills and personality. The second resident was having breakfast and engaging in their morning routine on their day off from work, while a third resident was participating in day services at another location operated by the provider.

The inspector had met with all three residents on previous inspections and residents discussed with the inspector developments that had occurred in the house since their last inspection. While residents were positive about many aspects of living in this centre, ongoing issues which negatively impacted on their day-to-day lives had not been adequately addressed by the provider.

Residents were aware of the delays in the transition to their home, however they spoke of their frustrations of not knowing when they would move and made formal complaints regarding this matter. Residents also expressed disappointment that they were only able to view the outside of the property and were unable to visit and see the inside. One resident had recently made the decision that they did not want to relocate to the area where the house was situated since it would affect their independence when it came to travelling to work and seeing their friends independently. The inspector found that the resident was encouraged to explore other options within the wider organisation. The resident gave the inspector an update on their transition to a different community house that had one vacancy. They had visited the house and met with other residents living there, and spent time with staff.

On a review of documentation, it was clear that it was important to one resident that staff knew how to respond to a medical condition and that they were distressed by these incidents. The resident's rescue medicine was to accompany the resident at all times when they left the house. As part of their person-centred plan, the resident was actively working on the goal of carrying and looking after their rescue medicine in the event of a medical emergency; however, they could not administer this themselves and required trained staff support. The inspector met with the resident when they returned to the centre from being in their day programme. The resident

was observed to have their rescue medicine on their person, and the resident showed the inspector the new bag they purchased for its safekeeping. While the resident had not required the administration of this medicine in two years, the inspector found that the high level of untrained staff had impacted the resident's right to feel safe and supported in managing their healthcare condition.

In the September 2021 inspection, it was found that the provider had difficulties ensuring that the centre was staffed by a consistent and regular staff team. During this inspection, staffing was highlighted to the inspector by management and residents and remained a significant issue. As was the case on the previous inspection, residents expressed concern that they did not always know the staff that were supporting them due to different staff being sent by an external employment agency. The inspector found that residents made a number of complaints in relation to unfamiliar staff being on phones, receiving small meals and dress codes.

An agency employee who had worked in the centre for the previous year was interviewed by the inspector, who was able to show that they had developed positive working connections with the residents. They were able to discuss the likes and dislikes of residents and the best strategies to use if any resident was feeling upset, depending on the individual's preferences. They advised the inspector that they were unable to administer medicines but could explain the process of contacting the provider's nurse-on-call after-hours service in this situation. The staff member emphasised how important it was for residents to get their medicines on time and how this could result in distress if this did not occur. For instance, the staff member was aware that residents wanted to get to work in the morning and would ring an hour in advance to guarantee that a nurse would arrive on time so residents could leave on time.

This inspection highlighted there had been an overall absence of appropriate oversight and lack of follow up to the concerns raised on the previous inspection of the centre. In the previous inspection residents inquired "why so many different staff were working on the day shift". Families also expressed that they would like to see more permanent staff for continuity of care as wished by their loved ones.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This centre was previously inspected in January and September 2021, where concerns were found with the size, layout and accessibility of the centre for all residents living in the property. The provider had previously communicated with the office of the Chief Inspector that they were unable to secure a further lease on the property for the duration of the registration cycle as required by the regulations. The

provider had informed the Chief Inspector that they had intended to secure an alternative property and provided monthly updates to that effect until September 2021, when a property had been identified for purchase by the provider. As a result, the centre's registration was renewed until January 2025 with a restrictive condition reflecting the absence of a lease and premises issues. The aim of this condition was to ensure that the provider carried out the works necessary that will allow residents to transfer to their new home by 30 September 2022. Due to delays in fire safety and refurbishment works, the provider requested an extension to the restrictive condition with a new due date of 30 June 2023, and this variation was granted.

The purpose of this inspection was to assess the progress the provider had made in relation to the transition of residents before the due date of 30 June 2022. Prior to the inspection, the office of the Chief Inspector had not received any notice from the provider regarding the formal closure of the centre, nor had they received an application to register a new centre as legally required. While key members of the management team were not available during this inspection, the inspector found there was poor knowledge of the status of the restrictive condition or of the requirements in informing the Chief Inspector of proposed changes to the registration conditions of the centre.

The person in charge had been working in the centre for 15 years. As a result, they demonstrated that they were very knowledgeable about the residents' assessed needs and the day-to-day management of the centre. They were supported by a PPIM, a clinical nurse manager (CNM3). The inspector found increased levels of oversight from the PPIM level of the centre, with detailed monthly meetings between the person in charge and PPIM discussing various aspects of care and the operations of the centre. The inspector found that the provider was currently reviewing the roles and responsibilities of persons within their organisation and had informed the Office of the Chief Inspector that notifications would be submitted in due course of transfers of persons in charge among the designated centres. Since the previous inspection, the person in charge had received an increase in administration hours from four to ten hours to support them in carrying out their legal responsibilities. The person in charge also informed the inspector that they had received recent training in the regulations and assessment judgment framework and that they found this training beneficial in increasing their knowledge base in this area.

However, the person in charge was not informed of any decisions made by the provider regarding the soon-to-be-expiring registration condition. The inspector viewed documentary evidence that the person in charge had requested further information in January 2023 regarding the non-adherence to this condition if the premises works were not to be completed in time. The inspector was not presented with any evidence during the inspection that this issue had been discussed at a senior management level.

On the previous inspection, staffing was found to be substantially compliant due to the level of non-familiar staff working in the centre. Despite the submission of a compliance plan to address this area of concern, the inspector found the plan had not been successful in improving continuity of care. The staffing arrangements in

place at the time of the inspection and for the previous six months had significantly decreased since the previous inspection. The inspector found this had resulted in negative outcomes for residents. While the provider was actively running recruitment campaigns and open days to recruit staff, and a new staff member was due to commence in the following month, there remained inadequate oversight of the use of relief and agency staff in the centre.

The inspector reviewed the arrangements in place for staff to raise concerns and oversight of staff practices. In addition to supervision meetings, staff also attended regular team meetings, which provided a forum for them to raise any concerns. Staff spoken with advised the inspector that they were confident in raising any potential concerns with the person in charge. However, due to the large number of non-permanent staff working in the centre, it was not feasible for the person in charge to conduct supervision with all staff or have them attend meetings. Staff members placed through an agency did not form part of the organisation's training and development programme. While the provider had a service level agreement in place with the agency provider to ensure agency staff had sufficient training, these records were not available on the day of the inspection for review. The regulations state that persons placed in employment by an agency provider should be afforded the same supervision, training and oversight arrangements by the provider.

Regulation 14: Persons in charge

The person in charge was full-time in their role and had worked in the centre for many years. They had relevant social care and management qualifications and were found to be suitably skilled and experienced to manage the centre. The person in charge had responsibility for this centre only. Their role was not fully supernumerary, so they also provided direct support to residents.

They demonstrated a rich understanding of the residents' needs and were aware of the regulations and standards pertaining to the Health Act 2007, as amended.

Judgment: Compliant

Regulation 15: Staffing

The inspector reviewed the past and the current rosters. The review of rosters found that the provider had been unable to attain a whole staff team to support the residents. Despite initiating a number of new recruitment strategies to improve staffing arrangements in the designated centre, the provider heavily relied on relief and agency staff to maintain safe staffing levels.

As laid out in the centre's statement of purpose, the centre had a whole-time equivalent (WTE) of three social care workers to support residents. This also

included the person in charge support hours, which totalled 29 hours a week. For the most part, staff were lone workers apart from Mondays and Fridays when a second staff was rostered to facilitate residents' days off from day services and work. A second staff member was also rostered on Saturdays for 4.5 hours so residents could engage in additional activities in the community. As previously mentioned, due to vacancies in the centre since November 2022, a large number of shifts were being covered by relief and outside agency staff.

As found in the previous inspection, the inspector found unsatisfactory arrangements to oversee and monitor the quality and continuity of care being provided to residents. Examples of this included untrained staff accompanying residents in the community, documented complaints made by residents, medicine errors and incidents that had occurred in the centre. Reviewing the rosters, the inspector calculated that 36 different agency and relief staff had worked in the house since January 2023. The person in charge was not responsible for organising the cover required on the rosters; this was managed through a centralised office.

In addition, Schedule 2 files were not maintained for all staff working in the centre as required by the regulations, which included a vetting disclosure in accordance with the National Vetting Bureau, written references and evidence of qualifications.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider did not have an adequate system in place to ensure all staff, including agency staff, were appropriately trained and supervised. Furthermore, training records for all staff were not easily retrievable for monitoring or review. It was not known how many agency staff had the required training to support residents' medical needs. The inspector requested the training records of these staff; these were not available during the inspection for review by the inspector. It was explained that it would take some time to comply these records as they were not routinely requested from the agency provider. Training records were submitted post-inspection, but these only accounted for 22 of 36 staff members requested.

Supervision arrangements were not found to be appropriate in this centre as the mast majority of staff worked unsupervised and were not subject to the provider's formal supervision process. Rosters demonstrated on some occasions that agency staff were handing over to other agency staff. Therefore an effective induction process was not taking place with all new staff.

The provider had committed in their previous compliance plan to ensure that all agency workers had the required mandatory training; however, the inspector was not provided with evidence that a system was in place to oversee this assurance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not taken the required actions in a timely manner to ensure that they came into compliance with the regulations by 30 June 2023 as required by their conditions of registration. As a result, the inspector found that the provider was on course to breach this condition.

Provider-level audits and reviews, as required by the regulations, had been completed; however, a clear action plan and progress were not evident to ensure timely improvement in the overall quality and safety of care. An annual review had been completed in September 2022, which involved a visit to the centre by the quality and risk officer. However, this was for the year 2021, and while some of the findings were relevant and current, others were not. For example, the overview of incident reports referred to 2021 only. The timings of such reviews required improvement by the provider to ensure the annual reviews captured a 12-month period accurately and against national standards. Similarly, communication systems between key stakeholders required significant improvement to ensure up-to-date information was available in order to identify issues and respond accordingly.

The most recent six-monthly audit was conducted over three dates in November and December of 2022, with sections completed by varying persons. The auditors had identified concerns with the staffing arrangements. Residents requested a reduced reliance on unknown relief and agency staff, as noted in the summary of the engagement with residents, to support the continuity of the team. Nevertheless, the inspector discovered that these reports were not completely efficient at self-identifying areas in need of improvement. For instance, a question on the audit tool inquired if the staff had the requisite expertise, training, experience, and understanding of residents to meet the residents' assessed needs. Even though the training records of the vast majority of workers in the centre could not be reviewed, this question had been recorded as affirmative. Additionally, it was noted that the multidisciplinary team had reviewed the behavioural support plans; this inspection found these had not been reviewed since 2021.

Regulations state a plan should be put in place to address any concerns regarding the standard of care and support. While an action plan was devised following the six-month unannounced visit, it was unclear who held responsibility for monitoring and actioning the large number of non-permanent staff in the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose is an important governance document that outlines the service to be provided to the residents within the centre. The inspector reviewed the current statement of purpose and found that it contained the information that is required by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed the centre's adverse incident recording log. It was found that incidents were notified to the Chief Inspector in the manner as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were policies, procedures and systems in place to report, manage and respond to a complaint arising in the centre. Residents were aware of how to make a complaint and were supported to make complaints in response to incidents that had occurred in the centre.
Residents also tried to gain resolution regarding the absence of information regarding moving to another property through the complaints process.

The inspector found that while these complaints were still open, the complaints process timelines had not been followed in addressing and responding to the initial complainants. Residents made complaints in September 2022 but were only met by the complaints officer in January 2023 to discuss the complaint.

Judgment: Substantially compliant

Quality and safety

From speaking with residents and from what the inspector observed, it was clear that the uncertainties for residents regarding transitioning to their new homes and high levels of unfamiliar staff had impacted residents' experiences of receiving a quality and safe service. This inspection found that deficits in the capacity and capability of the provider resulted in insufficient risk assessment and poor responses to identified non-compliances with the regulations, residents' expressed wishes and

assessed needs.

Risk management systems did not provide assurance as to how risks and the control measures were consistently overseen so that the safety of residents and staff were protected and promoted. The inspector found that the roles and responsibilities of all layers of management in relation to risk were not evident in the centre. There was evidence that risks had been escalated by the person in charge and risk assessments developed in response to known risks, but was no documented response from the provider.

One resident, due to their assessed health needs, required staff to have specific training so they could respond in the event of a medical emergency. Due to the high volumes of agency staff and the failure of the provider to ensure all agency staff had this training, the centre was often staffed without this requirement. From November 2022 to January 2023, the resident could not freely access the community due to the lack of trained staff. The person in charge had recognised this restriction on the resident and had escalated this concern as part of the monthly reviews of the centre. The person in charge had developed a risk assessment as requested, which assessed the probability of needing the emergency medicine risk as low, negating the need for the resident to be accompanied by trained staff.

While the resident had not required this medicine in two years, all documented evidence from healthcare professionals, including the prescription for the administration of this medicine, remained unchanged. For example, the health condition care plan devised in July 2022 and updated in March 2023 stated that the resident was to receive the medicine after two minutes, and the recommendation was to contact an ambulance after two doses had been given. This plan had not been updated with the change in the process of contacting the nurse on call if the resident needed the administration of this medicine. It was also not evident that the provider had appropriately risk assessed the resident requiring this intervention at night time in the absence of trained personnel.

There were systems were in place to safeguard the residents, and where required, safeguarding plans were in place. The inspector observed that there were two safeguarding issues currently open in the centre, and these related to adverse peer-to-peer verbal interactions. The inspector found all adverse incidents were being recorded, reported and responded to by the person in charge. The inspector noted that there was a reduction in safeguarding concerns due to the effectiveness of the safeguarding plans implemented. Residents were well supported to manage to own finances and possessions. Where required, staff members maintained residents' finances, and detailed records were in place for all financial transactions. Records of residents' personal possessions were also in place, which assisted in ensuring that their property was safeguarded. Residents who met with the inspector also indicated that they were free to spend their money as they wished.

On review of the systems in place and supports available to address behaviours of concern, the inspector noted that the provider had in place a referral pathway for residents to access positive behavioural supports in a timely manner. Overall the inspector found behavioural supports were effective in supporting residents and

staff; however, behavioural support plans were not subject to regular reviews as required by the regulations, and the presence of unfamiliar staff did not positively impact supporting behaviours of concern. Apart from complaints made by residents, the inspector reviewed one incident report that was the direct result of one resident being upset about having to wait for over an hour for their evening time medicine.

Regulation 12: Personal possessions

There was good record keeping at a local level regarding any money belonging to residents that was received or spent while in the centre. The financial accounts of residents who received the provider's support with their financial affairs were well managed, and these were audited regularly to ensure measures were in place to safeguard residents' finances.

Financial passports were on file for each resident, and residents' contributions towards their accommodation were assessed yearly through national and provider assessment processes.

Judgment: Compliant

Regulation 17: Premises

As discussed in the report, the provider did not meet the requirements of this regulation or the criteria set out in Schedule 6, namely, adequate private and communal accommodation, adequate space and suitable storage facilities, and baths, showers of a sufficient standard suitable to meet the needs of residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

Given the risk posed by the staffing levels to residents' safety and overall wellbeing, the centre's risk register was reviewed by the inspector. Although the register had been recently reviewed, the systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies were not effective.

The provider had not outlined additional measures to reduce or mitigate against high-rated risks. Based on the findings of this inspection, it was not clear what risks had been reviewed above the level of the person in charge. Some individual risk assessments were not an accurate reflection of the risks posed and the controls in

place in the centre. Not all hazards in the centre had been risk assessed accurately, including the low number of staff trained to administer medicines and the impact of this on the service provided to residents.

At the time of the inspection, the provider had not appropriately risk assessed the level of staff that did not have training in rescue medicine, nor had they thoroughly reviewed the impact this had on residents who required this expertise in their support staff. The provider had not risk assessed the fact that if the resident required this medicine either within the community or in the centre within two minutes of the medical emergency, on-call or ambulance support was not feasible.

Judgment: Not compliant

Regulation 6: Health care

For the majority of identified healthcare and mental health needs, residents' needs were monitored within the centre on an ongoing basis. However, due to the staffing arrangements, epilepsy support could not be implemented if required in the presence of untrained staff. This posed a risk to residents' safety while in and outside of the centre.

On a small number of occasions residents did not receive medicine from on-call nursing support. This had not been identified due to unfamiliar staff working in the centre. Subsequent to one of these drug errors (missed administration of medicine) a resident had a seizure.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents with assessed behaviour support needs had behaviour support planning arrangements in place. Some residents engaged directly with the provider's psychology services frequently, as often on a weekly basis. One resident showed the inspector one tool they used that they found helpful as a result of these meetings.

The resident had a behaviour support plan in place since August 2021. The inspector was informed it had been developed by a clinical psychologist. However, there was no documentary evidence of this input. The plan was also not updated since, in light of changing dynamics in the house or minimally as required by the regulations.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. There was an up-to-date policy in place to guide staff practice.

The inspector found that safeguarding concerns were reported and screened, and safeguarding plans were developed as required. Staff spoken with able to describe the safeguarding procedures and were knowledgeable on the safeguarding plans.

The inspector was unable to determine the safeguarding training status of all staff working in the centre, and this is actioned under Regulation 16.

Judgment: Compliant

Regulation 9: Residents' rights

As evidenced under regulation 15: Staffing, the inspector found that there was poor continuity of care and support for residents. This, the inspector found, demonstrated that care and support was not continuous and was found to be a cause of anxiety for the resident group and members of the staff team. Both residents and staff members expressed concerns about continuity of care and support to the inspector during the course of the inspection.

There was clear evidence to demonstrate that some residents expressed wishes about their care and support needs were not always supported or promoted. The inspector found that the provider was not authentically engaging with residents to ensure they were well-informed or updated regarding their concerns.

There were some restrictions on the ability of some residents to exercise choice and control over their daily lives which resulted in negative impacts on their overall wellbeing and emotional state.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Charnwood Gardens - Community Residential Service OSV-0003072

Inspection ID: MON-0035789

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 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. The provider will ensure that residents receive continuity of care by ensuring familiar and regular staff are rostered. The provider has now recruited two full time staff members to fill the remainder of vacancies which totals 78 hours.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge and PPIM has completed a training analysis which meets the needs of the residents residing within the centre. Training has been provided to relief and agency staff to ensure they correct skill set to support residents identified needs. The orientation of all relief staff has been reviewed by the PIC to ensure appropriate supervision of all staff.	
Regulation 23: Governance and	Not Compliant

management	

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.
The provider has recruited two new social Care workers to ensure effective delivery of care and support for all residents as per statement of purpose
The PIC and senior management team have completed additional training to support the completion of provider audits to ensure that they are identifying areas of noncompliance.
The provider will remain in regular contact with key stakeholders to ensure they are up to date with all conditions of registration. This will be fed back to the PPIM and PIC.
The Provider will ensure the annual report is carried out in line with regulation and reflects activity in the centre for the previous 12-month period. The Provider will also ensure there is a current action log maintained to reflect the status of actions from audits/reviews/ reports .
The provider is in the process of submitting an application to vary on its current condition of registration. The provider is awaiting the handover of a completed property by the housing authority.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The registered provider shall ensure that all complaints are investigated promptly. The PIC will review the complaints procedure within the house and ensure that all staff are familiar the complaints procedure and how to deal with a complaint as per policy. The PIC and PPIM have regular meetings since January 2023 where all complaints are reviewed and dealt with promptly

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider will ensure are supported to live in a home based within their own will and preference. A property has been sourced, and work is being completed to ensure its fit for purpose. The provider is waiting for the property to be handed over by the property authority. The provider is seeking assurance that this property is meeting each residents individual will and preferences. The PIC will ensure that any resident who has indicated that they may like to live elsewhere is supported in this decision making process.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The provider has filled all vacancies within the centre.
The provider has ensured that all staff working in the designated centre are appropriately trained to meet the assessed needs of all residents. The PIC will ensure that care recommendations are reviewed by medical personal to ensure they reflect the current assessed need of the resident.
The PIC has been provided with training in risk management and an understanding of risk and positive risk management. The PIC will ensure that risk assessments are reflective of current risk and any additional actions are escalated to the provider. The provider continues to maintain a risk register which is located in the providers office. This is discussed with PIC and PPIM meetings and the PPIM updates the PIC on relevant risks to the designated centre

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The provider has ensured that all staff working within the designated centre are appropriately trained as per the assessed needs of residents. The provider has ensured that systems are in place to ensure that all residents are supported by appropriately trained staff to provide the necessary care as per there assessed needs. Each person within the designated centre will have appropriate plan of care.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC has ensured that there is evidence of plans of care developed by psychology and documented evidence of psychology input within the residents careplan which are

reflective of current assessed needs. Staff working in the area are being supported to attend training to support residents with behaviours of concern.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Provider will ensure that residents are supported by a regular staff to meet their assessed needs and ensure continuity of care. The PIC will ensure that all residents receive up to date information and are kept well informed about developments. The provider has systems in place to support the residents voicing their complaints. The provider continues to support residents to explore their will and preference in relation to their home and the future.

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(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.	Not Compliant	Orange	30/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/10/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	04/01/2023
Regulation 23(1)(a)	The registered provider shall ensure that the	Not Compliant	Orange	30/06/2023

	designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	04/01/2023
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	30/10/2023
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated	Not Compliant	Orange	30/07/2023

	promptly.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/10/2023
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/08/2023
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/06/2023
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	Not Compliant	Orange	30/06/2023

	disability has the freedom to exercise choice and control in his or her daily life.			