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:	Community Living Area 9
Name of provider:	Muiríosa Foundation
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	02 March 2023
Centre ID:	OSV-0004081
Fieldwork ID:	MON-0036226

About the designated centre

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

This designated centre provides a full-time residential service to four adult females between the age of 18 and 85 who have an intellectual disability. The designated centre is situated on the outskirts of a small village in Co. Kildare. The centre is a bungalow which has been decorated to resident's personal tastes and interest. The designated centre consists of a kitchen, a store room, a utility room, two sitting rooms, and five bedrooms two of which are ensuite. There is a bathroom downstairs and shower room upstairs. The person is charge works full-time and divides their time between this and another designated centre. Residents are supported 24 hours a day seven days a week by a team of social care workers and health care assistants.

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 2 March 2023	11:10hrs to 18:50hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

The purpose of this unannounced inspection was to assess the levels of compliance with the regulations since the previous inspection in October 2021. Overall, a good level of compliance was found during this inspection, and there was evidence of strong monitoring systems in place. The inspector of social services found that the person in charge and senior management were responsive to changing needs in the centre whilst reviewing long-term plans for emerging healthcare needs. However, the inspector found deficits in the application of both the national and the provider's safeguarding policies and procedures.

On arrival at the centre in the morning, the inspector was greeted by a member of staff. The inspector was informed that two residents were attending an arts and crafts programme in the community, and one resident was in bed as per their wishes. The inspector learned that one resident had transitioned to a specialised residential home four days ago in line with their changing needs over the previous year. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

As per the centre's statement of purpose, the designated centre provides residential care for a maximum of four residents with intellectual disabilities and ageing-related needs. As residents' needs changed, cognisance was given to ensuring the environment met those changing needs. While the centre was a two storey-building, all residents' bedrooms were located on the ground floor, which had recently had a number of upgrades to ensure residents' needs were effectively met. These included a fire exit for residents to exit in the event of a fire and a refurbished accessible bathroom.

Walking around the house, the inspector observed that residents had personalised their bedrooms and had their photographs and personal items displayed. Residents spoken with informed the inspector that their bedrooms were comfortable and homely. One resident showed the inspector their bedroom and en-suite, and it was observed the resident had ample room for all their belongings.

The inspector met with the three residents that lived in the centre over the course of the inspection. Residents were able to express their opinions of what they liked about living in the house, and the feedback received from residents was mostly positive. It was clear that residents viewed the centre as their home and enjoyed the services that were available to them. It was also evident from speaking with residents and staff that residents had strong connections to family and to their local community. Each resident had their own personal folder of photographs showing them participating in a variety of activities and progress made towards goals.

Residents were supported by a team of social care workers and healthcare assistants. The inspector observed that staff had a very positive approach with

residents, who appeared to really enjoy the company of staff. There was a relaxed atmosphere, with residents talking to staff about their plans for the week. Throughout the inspection, residents were observed to receive support and assistance in a kind, caring, respectful manner. Each resident who spoke with the inspector was complimentary towards the staff team.

From speaking with residents, staff and reviewing documentation, it was clear that some incidents had occurred in the centre that had led to residents feeling upset. One resident made two complaints to management to this effect, stating they could not sleep. Overall, the inspector was satisfied that corrective action had been implemented in response to such complaints. These included additional support hours, multi-disciplinary reviews and reviewing placements in line with changing needs. Residents spoken with told the inspector the house was a lot quieter as a result and this made them happy.

It was evident that residents were allowed to express their views and preferences and were provided with information relating to the centre and their care. One resident was an active member of the organisation's 'People First' advocacy group. They previously met the inspector during a resident's forum group meeting with the Health Information Quality Authority (HIQA). The purpose of this meeting was to gain feedback from residents regarding their views on services, their rights, the impact of COVID-19 and the inspection process. Residents also contributed and gave feedback on centre records, including residents' guides and easy-to-read documentation.

Overall, the inspector found that residents were supported to have a good quality of service, with access to day service, the local community, friends and family. Residents were supported to contribute to the running of their centre with weekly meetings in place and support meetings taking place with key workers to evaluate and develop individual goals.

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.

Capacity and capability

As previously mentioned, the inspector noted improvement was needed with the application of safeguarding procedures. While the provider had taken successful action to respond to changing needs in the centre, compatibility concerns were addressed inappropriately through the complaints process instead of the safeguarding process. The 'Quality and Safety' section discusses this in more detail. Aside from these matters, there was evidence of good oversight of the service provided to residents.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and to who they were accountable to. Staff reported to the person in charge, and they reported to the person participating in management. Since the July 2021 inspection, there had been a change of person in charge that occurred in March 2022. They had the necessary skills, experience and qualifications to perform the role. At the time of this inspection, the person in charge was responsible for a total of two designated centres.

The person in charge was not met with during the inspection as they were not due to work that day. Instead, the area director, a person participating in the management of the centre, facilitated the inspection.

There was evidence that regular staff meetings, and one-to-one meetings as part of the provider's performance management system, were taking place. These provided staff opportunities to discuss aspects of the quality and safety of the care and support provided to residents and ensure consistent practices. The provider had an online training recording, request and review system, which enabled the person in charge to maintain oversight of completed training. There was evidence of shared learning being applied from other inspection findings. In particular, the record-keeping of infection, prevention and control training certificates.

Under regulations, the provider must ensure appropriate staffing numbers and skill mix in place to support residents. Based on the findings of this inspection, the inspector was satisfied that the provider was reviewing the staffing requirements in line with residents' needs, changes in circumstances and fire evacuation procedures within the centre.

The provider had completed an annual review of the quality and safety of the centre for 2021 (the review for 2022 was under review at the time of the inspection) and six-monthly unannounced visits to the centre. Unannounced visits took place in April and November 2022. Where identified, there was evidence that areas requiring improvement were being progressed or had been completed; for example, amendments had been made to the centre's statement of purpose and residents' guide of the centre. It was also identified during the previous six-month visit that additional fire drills were required so all staff should have the opportunity to part take in drills ensuring they felt comfortable with the procedure.

In advance of this inspection, the inspector reviewed notifications that had been submitted regarding this designated centre to the Chief Inspector of Social Services. Certain occurrences that take place in a designated centre must be reported within three business days, as required by the regulations. This is necessary so that the Chief Inspector is aware of any incidences that may have a detrimental impact on residents. Statutory notifications are an indicator of quality and safety within a service. They are a source of information on the frequency and types of events that occur within a service, and they also offer an insight into how a service responds when something goes wrong. Notifications submitted by the person in charge were of good quality and gave assurances to the Chief Inspector.

The inspector reviewed the centre's statement of purpose, which was submitted post-inspection. This is an important document that sets out information about the centre, including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. This document met the majority of the requirements of the regulations. The regulations require the provider to review and update the statement of purpose at least once a year, and the documentation submitted was slightly outside of these dates.

Regulation 14: Persons in charge

The provider had ensured that a person in charge had been appointed to work full time and they held the necessary skills and qualifications to carry out their role.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were found to be based on the needs of residents living in the centre. The provider had responded to changing needs in the house by appointing additional support hours. Since the previous inspection, 15 extra hours had been allocated on a weekly basis as a risk measure to support residents in attending activities of their choice during the week due to changes in the home environment. These hours were fulfilled by regular relief staff that were known to residents.

The provider also increased night-time staff to ensure residents could be evacuated from the centre; at the time of the inspection, two sleep over staff were in place. The staff who spoke to the inspector were very knowledgeable regarding residents' needs.

Judgment: Compliant

Regulation 16: Training and staff development

A review of training records indicated that there was good oversight in this area, and the staff team had attended training in the areas identified as mandatory in the regulations. These included fire safety, training in safeguarding residents and the prevention, detection and response to abuse, and infection prevention and control.

Team meetings were occurring every second month in the centre, chaired by the person in charge. These were found to be resident-focused and of a high quality so that staff were kept well informed of changes to residents' needs as well as the

provider's policies and procedures. Standing agenda items included COVID-19, the wellbeing of residents and changing needs, adverse incidents, complaints, risk assessments, quality improvement plans and training.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure in place, consisting of an experienced person in charge who worked on a full-time basis in the organisation and was supported by an area director.

There was evidence of regular quality assurance audits taking place to ensure the service provided was effectively monitored. These audits included the annual review for 2021 and the provider's unannounced six-monthly visits as required by the regulations.

It was seen that the November 2022 provider's unannounced visit was reflected in a written report with an action plan to address issues identified.

The person in charge was also completing a number of other audits in the centre, and the inspector observed documentation about areas for improvement that they had identified through these audits.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider maintained and made available in the centre a statement of purpose; the record contained all of the required information and was an accurate reflection of the centre.

There is evidence of reviews and necessary revisions of the statement of purpose but not as frequently as required.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A low number of qualifying three-day notifications had been submitted for 2022, and these referred to incidents of COVID-19 in the centre. Other incidents of a lesser

nature that require being notified, every quarter, include minor injuries. Reviewing these incidents, the inspector noted that the records contained detailed notes indicating that a person-centred approach was taken and the required supports are provided, both in the immediate aftermath and on an ongoing basis, to keep residents safe and promote their wellbeing.

While safeguarding concerns had not been notified, the inspector found this was not due to the failure of the person in charge. They had accurately identified these incidences as safeguarding concerns and had escalated these through the safeguarding pathways within the organisation. This issue is actioned under Regulation 8: Protection.

Judgment: Compliant

Quality and safety

Overall, a high level of compliance was found during this inspection, and there was evidence of strong monitoring systems in place. The inspector found that the person in charge and senior management were responsive to changing needs in the centre whilst reviewing long-term plans for emerging healthcare needs. However, the inspector found deficits in the application of both the national and the provider's safeguarding policies and procedures. Improvements had been made to the fire safety precautions since the previous inspection; however, the inspector noted that the drills required review.

During the previous inspection, it was found that improvements were required in relation to fire safety, in particular fire egress and fire containment measures. The timeline and schedule of works were sent to the Chief Inspector after the inspection. The provider had identified an inadequate number of escape routes suited to the residents' mobility needs, and some fire doors were ineffective. During a walkaround of the centre of this inspection, the inspector observed a new exit route had been installed leading outside from the living room. Residents spoken with understood the purpose of the new exit route and demonstrated good awareness of the fire procedures in the centre. On review of the fire drills carried out in the centre it was not demonstrated that fire drills simulated night-time conditions.

The inspector reviewed a sample of the residents' assessments and personal plans. These provided guidance on the support to be provided to residents and had been recently reviewed. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs, including communication abilities and preferences, personal care, healthcare and other person-specific needs. In addition, residents' personal plans demonstrated that they were facilitated and encouraged to engage in activities and their communities in a meaningful way.

Under Regulation 5: Individualised assessments and personal plans, there are

specific requirements that must be adhered to in preparing, reviewing and presenting personal plans. From the sample reviewed, it was seen that some of the requirements had been met. These included the personal plans being subject to an annual multidisciplinary review, while the contents of personal plans were found to have been reviewed within the previous 12 months. Improvements were identified to the personal planning process, including conducting and recording the effectiveness of the personal plans, recommendations and rationale for any changes.

It was evident that residents' changing needs were continuously reviewed to ensure specific care and supports could be delivered. Residents had access to the organisation's occupational therapist, behaviour therapist, advanced nurse practitioner and physiotherapist.

As referenced in the opening section of this report, the inspector was made aware during the course of the inspection of adverse incidents in the centre that had affected residents negatively. While the provider had policies and procedures relating to safeguarding and protection in the centre, allegations and suspicions of abuse were not reported and followed up in line with organisational and national policy. The inspector found that there had not been a satisfactory level of scrutiny by the registered provider of all alleged incidents to guarantee that safeguarding arrangements in place ensured all residents' safety and welfare.

The inspector reviewed a sample of documentation relating to alleged safeguarding incidents that had taken place over the last twelve months. The inspector found that, overall, the incidents had been actioned in an effective manner. For example, the provider had implemented a number of additional control measures to support residents overseen by the multi-disciplinary team. However, the inspector viewed information received by the person in charge from the provider's safeguarding team that conflicted with the safeguarding policy. As a result, adverse incidents that impacted residents were not screened through an investigation process and notified to national safeguarding teams within the Health Service Executive (HSE). The inspector brought this information to the attention of the management at the feedback session.

Regulation 13: General welfare and development

The inspector found that residents' welfare and development was provided for to a high standard. Residents were well supported socially and had good levels of community involvement and activity. Each resident had the opportunity for new experiences, social participation, recreation, education and training. Access was determined by individual needs, abilities, interests and choices.

Judgment: Compliant

Regulation 17: Premises

The designated centre is a large dormer bungalow. The house has six bedrooms, four of which are for residents' use and are located on the ground floor. There are two sitting rooms and a combined kitchen and dining area. There is an accessible bathroom downstairs and a staff office and bathroom upstairs. There is a conservatory accessed through the kitchen down some steps. This area was mostly used for storage purposes and was not freely accessible from the house for all residents. However, this was in line with the centre's statement of purpose that the room was used for storage of equipment and to facilitate therapeutic activities, for example, gardening projects. The inspector observed that residents could access the room via the garden.

The inspector viewed one resident's bedroom. The room had been personalised to reflect the resident's interests. Photographs and the resident's preferred items were on display.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had addressed fire safety concerns from the previous inspection. The fire evacuation procedures and route were in line with residents' assessed needs. Fire doors were held open by a magnetic closure that activated in the event of a fire; this type of fire door closure promoted the unrestricted movement throughout the centre. The inspector observed documentation that an emergency light was due to be installed outside of the new emergency exit; however, in discussions with management, it was identified that the work had not been completed. This outstanding action was rectified the day after the inspection.

It was noted that records of such drills did not reflect night-time situations when staffing levels would be at their lowest.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents’ personal plans also included plans to maximise their personal development in accordance with their wishes. Current goals were noted to be personal to the residents and reflected their interests and things that were important to them. One resident showed the inspector their goal planning folder and spoke about their achievements, such as taking part in a study in a Dublin

University. Where residents needs' were changing, it was apparent that all efforts were being made to meet these needs.

Personal plans should be informed by a comprehensive assessment of all health, personal and social needs, conducted annually at a minimum. The inspector observed this practice occurring. However, not all requirements of this regulation were met, as listed below:

- The multi-disciplinary review of the residents' personal plans did involve assessing the plan's effectiveness and taking into account changes in circumstances and new developments.
- Recommendations leading out from these reviews, including any proposed changes to the plan, the reason for these changes and names of those responsible for pursuing objectives in the plan, were not recorded.
- Personal plans had not been developed with the participation of each resident and or with their representative.
- In addition, the regulations require personal plans to be presented in an easy-to-read format, but the inspector was informed that these were not in place.

Judgment: Substantially compliant

Regulation 6: Health care

The allied health team and management carried out quarterly reviews of all residents, which formed part of planning for future ageing needs. It also allowed for issues such as mobility, centre design and layout and transport requirements to be flagged to the provider in a timely manner.

Appropriate healthcare was made available to residents having regard to their personal plans. In cases where a healthcare need had been identified, a corresponding healthcare plan was in place. These included health action plans for osteopenia, cholesterol, wound care and epilepsy.

There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required.

Judgment: Compliant

Regulation 8: Protection

Safeguarding mechanisms were not robust, and the inspector found that the arrangements did not support the person in charge to carry out their responsibilities under this regulation. Not all incidents of a potential safeguarding nature were

appropriately screened by the provider's safeguarding team.

Some incidents reports referred to residents being upset and crying, however no referral had been made to the relevant safeguarding and protection team. Furthermore, there was an absence of safeguarding plans, oversight and review as per national policy.

The inspector requested to review the organisation's policies and procedures in relation to safeguarding vulnerable adults. The policy clearly stated the procedures to be followed and the roles and responsibilities of staff. It listed indicators of emotional and psychological abuse, including tearfulness and increased self-injurious behaviour, both of which were observed and recorded in the centre's incident logs. While it was clear the provider's policy identified the procedures to take place following the presence of such indicators, communication reviewed during the inspection indicated a 'threshold' of safeguarding had not been met. Therefore allegations and suspicion of abuse were not screened through approved processes.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector observed there to be many examples of where the residents' rights were promoted.

There was a self advocacy group within the organisation and a complaints policy and procedure in place to support residents and their families raise any issues the may have in relation to the service provided.

Residents rights were respected in the centre with residents having choice and control in their daily lives. Key working sessions and residents meetings were used as platforms to discuss residents rights and advocacy regularly.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Community Living Area 9 OSV-0004081

Inspection ID: MON-0036226

Date of inspection: 02/03/2023

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 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The register provider will actively ensure appropriate reviews of the statement of purpose take place in a time sensitive manner. The statement of purpose has been fully reviewed following the recent transfer of one resident. The statement of purpose now denotes the accurate reflection of the number of residents cared for in the designated centre. The statement of purpose will remain as a live active document and will be reviewed and reflective of the current purpose of the service provided.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. The registered provider has ensured that works have been completed regarding fire safety. The emergency fire exit light is in situ and is activated above the new fire exit. This work was completed 06.03.2023. The registered provider will ensure that all staff members participate in a fire drill within the designated centre. This will be completed to ensure all staff members have the required exposure to be confident in fire drill. Fire drills will be completed for both day and night in line with statement of purpose.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The 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 is developed through a person centred approach with the maximum participation of each resident, and where	

appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Regulation 5 (5) (5): The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative

Regulation 5 (6) (b)The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability

Regulation 5 (6) (c)The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.

Regulation 5 (6) (d)The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.

Regulation 5 (7) (a)The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.

Regulation 5(7) (b) The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes

Regulation 5 (7) (c) The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.

Personal Plans will be evaluated bi- annually or more often if required, in conjunction with input from members of the multi-disciplinary team, the resident and their representatives, the Person in Charge and the staff team to ensure all aspects of the persons care is reviewed and updated where necessary. The effectiveness of the Personal Plan and any necessary changes will be clearly outlined following the review, alongside the rationale for any changes being implemented. The Personal Plan will identify which member of the team is responsible for ensuring recommendations are implemented and will include the rationale for any proposed changes to the plan. Accessible information will be prepared for the resident as identified through the personal plan e.g. antibiotic usage or prescribed new medication.

Regulation 8: Protection	Not Compliant

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

The registered provider will ensure that adequate escalation will be afforded in each instance of safeguarding and processed through the designated officer as appropriate. The provider will ensure that any instances that require notification in line with protection will be notified to the chief inspectors office within the required timeframe. The provider will ensure that they work within the scope of the organisations safeguarding vulnerable adults policy. Allegations and suspicion of abuse will actively be screened through the approved processes in line with the identified pathway.

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 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	23/04/2023
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	16/03/2023
Regulation 05(4)(c)	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 is developed through a person centred approach with the maximum	Substantially Compliant	Yellow	05/05/2023

	participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/09/2023
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/09/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is	Substantially Compliant	Yellow	30/09/2023

	the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/09/2023
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	30/09/2023
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed	Substantially Compliant	Yellow	30/09/2023

	changes.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	30/09/2023
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	05/04/2023