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:	No.4 Fuchsia Drive
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	16 February 2024
Centre ID:	OSV-0004478
Fieldwork ID:	MON-0042858

About the designated centre

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

No.4 Fuchsia Drive consistent of three detached houses located in a town that can provide full-time residential support for residents with intellectual disabilities and autism of both genders, between the ages of 35 and 75. Two houses can support a capacity of five residents each while the third can support four residents so the maximum capacity of the centre is 14 residents. One house is a three-storey house with the other two being two-storey houses. Each resident has their own bedroom and other facilities in the houses include bathrooms, sitting rooms, kitchens and staff rooms. Support to residents is provided by the person in charge, social care leaders, social care workers, care assistants and a nurse.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
Friday 16 February 2024	12:20hrs to 20:20hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Four residents were living in the house visited during this inspection. The inspector had a lengthy chat with one of these residents who generally provided positive feedback but did reference that other residents would give out to them. The other three residents were also met but did not engage with the inspector to the same extent. Staff on duty interacted appropriately with residents and a calm atmosphere was encountered on the day of inspection.

This designated centred was comprised of three separate houses, all located within the same town. Combined the houses could support up to 14 residents. While thirteen residents in total were present on the day of the inspection, just one of the three houses that made up the centre was visited, in keeping with the focus on this risk based inspection. As a result only four residents were met during the course of this inspection. Generally, the house visited was closed during the day time while the residents living there were away from the house attending their day services operated by the same provider. However, on the day of the inspection one resident was present when the inspector arrived to commence the inspection and greeted him at the house's front door. After showing the resident his identification and explaining why he was here, the resident invited the inspector into their home.

At the time the resident, who was having lunch, indicated that they were doing some cleaning and their laundry that day. As no staff were present, the inspector briefly left the resident to telephone management of the centre to advise them of his presence in the house. When he returned the resident had finished their lunch so the inspector sat with the resident and chatted with them. The resident told the inspector that they went to their day services four days a week but stayed at home one day a week which they liked as it gave them some peace and allowed them to do cleaning in the house. This cleaning appeared to be very important for the resident who also talked about the other three residents that lived in the house with them. The resident told the inspector that they liked living with these residents but said that sometimes there could be a lot of disruption particularly when two of the other residents gave out to them.

The resident then went onto talk about some family and friends as well as some medical appointments that they had recently attended. When asked, the resident said that staff had helped them to go to these medical appointments. They also mentioned that on the days when they were at home on their own, a staff member from their day services would telephone the house to check in on them. This was overheard to happen during the early stages of this inspection. The inspector asked the resident about the staff supporting them in their home. It was indicated by the resident that they there were usually two staff on duty and that they always knew who these staff were. The resident also said that they would be informed in advance of any staffing changes and that they had been told about a new staff member who commenced working in the house recently. It was pointed out by the resident that there was a noticeboard on display which showed photographs of the staff on duty

throughout the week.

A member of staff had been appointed as the resident's key-worker (a staff who is specifically intended to support an individual resident). The resident told the inspector that their key-worker had recently changed but that they knew who their key-worker was. The resident also indicated that they saw their key-worker often in the house and was aware of who the person in charge for the centre was. Overall, the resident commented very positively on the staff support that they received and indicated that they liked living in the house. The inspector asked the resident what they liked to do away from the house and the resident mentioned a group that they were involved with who went on outings. The resident said that they were going on such an outing later in the day but it was later clarified that this was planned for the following week. It was mentioned by the resident that there was always a car present for the house and that at the weekends they went "everywhere". The resident did inform the inspector though that sometimes they could not go out from the house if staff on duty could not drive.

Once this chat was over the resident resumed cleaning the house and was seen to take great care and attention in ensuring that kitchen surfaces were wiped down. The resident also advised the inspector not to walk on certain flooring as it was wet from cleaning. After finishing cleaning in the house's kitchen and sun room, the resident went upstairs to clean their own bedroom. When they had finished this the inspector asked if he could see their bedroom. The resident agreed to this and then showed their bedroom to the inspector. This bedroom was seen to brightly decorated, well-furnished and personalised to the resident, with the resident indicating that they liked their bedroom. After this the resident pointed out some other rooms in the house including the bedrooms of some other residents which were seen from their open doors. These too were observed to be well presented with facilities provided for residents to store their personal belongings in place. Communal areas within the house included the kitchen, the sun room and two sitting rooms. Such rooms were well-furnished and the house was seen to be clean and homelike on the day of inspection.

As the inspection progressed, one of the centre's staff management team and two staff members arrived at the house. The other three residents who lived in this house also returned from their day services. It appeared that one of the resident returned first and came into the staff office where the inspector was based at the time. This was a large room with a couch with the resident sitting on the couch. The inspector greeted the resident who said some words in response but the inspector found it difficult to make out what the resident was saying. This resident though was seen to smile on occasion and appeared quite content and relaxed remaining in this room, which they did for a period of time in the presence of the inspector with staff occasionally checking in with the resident. At one point a staff member brought the resident a cup of tea and on another occasion a meal was brought to the office for the resident. It was highlighted to the inspector that the residents in this centre had particular rooms where they tended to spend their time, with this resident liking to spend their time in the staff office.

The remaining two residents also returned with one of these overheard to be vocal

for a short period of time before being reassured by a staff member present. The inspector greeted this resident but they did not engage with the inspector at this time before going to one of the sitting rooms where they tended to spend their time. This resident was later seen doing some jigsaws with the support of a staff member. The final resident was also greeted by the inspector and did briefly engage with the inspector at one point. During this time the resident said the word "bus" and when asked by the inspector if this meant they wanted to go out, the resident indicated that it did. Soon after this the resident left the house with another resident in the car provided that was driven by one of the two staff on duty. When they returned, the second staff took another resident out in the same car. As the inspection neared its conclusion residents spent time in communal areas or in their bedrooms and, in general, the atmosphere was calm. The staff and member of management present were pleasant and warm towards the residents throughout the inspector's time in the house.

In summary, the house visited during this inspection was seen to be clean, well-presented and homely. Each resident had their own bedroom and all four residents living in this house were met on the day of inspection. Three of these residents were met after they returned from their day services while the other spent their day in the house. The inspector spoke at length with this resident who gave mostly positive feedback, but referenced other residents giving out to them and sometimes not being able to leave the house if staff present could not drive.

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

Some actions from a previous inspection in July 2023 had not been implemented. Appropriate staffing levels were maintained in the house visited. Despite this, staffing for this house was not in accordance with the centre's statement of purpose (SOP).

This designated centre had been previously inspected by the Chief Inspector of Social Services in July 2023. That inspection reiterated previous concerns (which had been first identified in July 2019) around the suitability of the premises provided in two of the three houses that made up this centre. In response to this, the provider indicated that they would seek to register a new centre which could enable some existing residents of the current centre to transition to in order to allow premises works to commence. In doing so the provider had given a time frame of 30 September 2024 to come into compliance with Regulation 17 Premises. Taking this into account, the centre had its registration renewed until December 2026. Since then the provider had made progress with this plan with the new designated centre

referenced being registered in January 2024. Some delays had been encountered which meant that residents had yet to transition there to enable premises works to begin in the current centre.

Aside from premises issues, in August 2023 the Chief Inspector received some information of concern relating to designated centres operated by the provider in a specific geographical area. This included the current centre with the information received raising concerns around medicines management and aspects of the governance of the centres involved. Consequently, the Chief Inspector sought a provider assurance report (PAR) from the provider seeking assurances in these areas. The provider's PAR response, received in September 2023, did identify some actions for the provider to address, but also outlined the systems in operation to ensure that appropriate medicines management and governance arrangements were in place. This PAR response was ultimately deemed to be satisfactory. However, in January 2024 further information of concern was received by the Chief Inspector. This raised some similar concerns as the August 2023 information but also mentioned concerns in other areas notably staffing. The January 2024 information was also specific to one particular house of this centre so the decision was made to conduct a risk based inspection focused on this house.

It was highlighted that the residents living in this house benefited from consistent and familiar staff. Accordingly, a core staff team was in place with regular relief staff available. No agency staff (staff sourced from an external agency) were indicated as working in this house also. The inspector was informed though that there had been some occasions when less regular relief staff had to work in the house to maintain staffing levels. This was particularly prevalent during the recent festive period and had been contributed to by annual leave and unexpected sick leave. On occasion, such factors could result in staffing for the house being changed at short notice but it was stressed by management that this was only done to maintain appropriate staffing levels. It was suggested though that such instances could result in residents being given only an hour's advance notice of staff changes. The inspector was informed though that each staff coming to work in the house would be inducted and there was an induction folder present in the house which had some information around the residents. It was seen though that some of the contents of this folder were from 2019 but it was indicated that updated information about residents was in their individual personal plans.

Records of staff having completed induction were not present within the house on the day of inspection. As such the inspector requested induction records for four specific staff members to be provided in the days following this inspection. He also afforded the provider time to confirm if additional staff meetings in this house had taken place and if all staff had received timely formal supervision. Records reviewed on the day of inspection indicated that a staff meeting had not taken place since August 2023 and that not all staff had received timely supervision in this house. In the days following the inspection, induction records were provided for two of the four staff requested. For the other two staff, it was indicated that they had received a verbal induction. Notes of one staff meeting from November 2023 were provided but these did not reference the channels for staff to raise concerns being discussed. This was something that the September 2023 PAR response indicated would be

covered at such meetings. Given that only one staff meeting had taken place since August 2023, this indicated that staff meetings in this house were happening inconsistently.

Post inspection information also confirmed that not all staff had received timely formal supervision despite this being highlighted as a regulatory action during the July 2023 inspection. Under the regulations, providers must ensure that appropriate staffing arrangements are in place to meet the needs of residents while also being in line with a centre's SOP. The centre's current and previous SOPs, indicated that there was to be a social care worker compliment of 2.2 full-time equivalent (FTE) working in the house. However, only one social care worker was assigned for this house at the time of inspection which amounted to a 0.5 FTE role. The inspector was informed that this had been the case for some time although there was some uncertainty on the day of the inspection as to the reasons behind this difference. Given the difference in the social care worker FTE as stated in the SOP versus the actual social care worker FTE in place for this house, it could not be said that staffing was being provided in accordance with the SOP.

It was acknowledged though that appropriate staffing levels were being maintained in the house which included the provision of one-to-one staff support for one resident to meet their needs and a waking night staff member supported by a sleepover staff. In the event that such night duty staff required support staff spoken with indicated that they could seek support from the other houses of this centre, which also had one waking night staff and one sleepover staff each. An out-of-hours on-call system was in operation with information about this on display in the house visited on this inspection with staff members present also aware of this. Records reviewed though did reference some concerns being raised around the absence of on-call support at times during January 2024. The inspector was informed that on-call supports were in place at these times but that there had been issues in the communication of changes in the on-call schedule for that month. This was put down to a technical issue which had since been resolved. The concerns around the on-call supports were referenced in daily communication that was issued to the management of the centre while the provider also had an incident recording system in place.

Part of this involved the maintenance of an incident log book. This was to record all incidents with each incident in the log book to be signed off by local management as stated in the opening pages of the log book. It had been identified during the July 2023 inspection that only a minority of incidents in such log books were being signed off as required. In response to that inspection, the provider had indicated that all incidents would be processed in accordance with the written guidance in the log book. Despite this, on the current inspection it was again found that only a minority of incidents recorded in this log book had been signed off by local management. As such the provider had not adhered to this aspect of their compliance plan response from the July 2023 inspection of this centre. The provider though had ensured that it had fulfilled its regulatory responsibility in October 2023 to conduct a six monthly unannounced visit to this centre. This visit was reflected in a written report which was made available to the inspector during the inspection

process.

Regulation 15: Staffing

Given the difference in the stated FTE for social care workers in the SOP versus the actual FTE social care worker complement in the house visited during this inspection, the staffing arrangements provided there were not in keeping with the SOP.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Records provided during the inspection process indicated that not all staff had received formal supervision in timely manner. This was despite a similar finding during the July 2023 inspection of this centre after which the provider had indicated that they would be in compliance with this regulation by 30 September 2023. Training records provided indicated that some staff were overdue refresher training in areas such as de-escalation and intervention, safeguarding and medicines management. Other records reviewed also indicated that staff needed training in Autism and some particular communication methods.

Judgment: Not compliant

Regulation 23: Governance and management

As was found during the July 2023 inspection of this centre, the oversight of an incident log book continued to need improvement. Staff team meetings were occurring inconsistently in the house visited on this inspection. Only one staff meeting had taken place in this house since August 2023. This notes of this meeting, from November 2023, did not reference the channels for staff to raise concerns being discussed. This was something that the September 2023 PAR response indicated would be covered at such meetings.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The SOP for the centre had been recently reviewed and contained all of the required information.

Judgment: Compliant

Regulation 4: Written policies and procedures

The medicines management policy provided during this inspection was last reviewed in June 2020. Under the regulations such a policy must be reviewed every three years. During a feedback meeting for this inspection it was suggested that a more up-to-date medicines management policy was in place. The inspector afforded the provider additional time to provide this up-to-date policy but none was submitted to the inspector.

Judgment: Substantially compliant

Quality and safety

While safeguarding plans were in place with staff aware of same, there had been some safeguarding incidents that had occurred in the house visited since the previous inspection. Medicine errors had also increased in recent months but these did not adversely impact residents.

The house that was focused upon during this inspection was also visited during the July 2023 inspection. During that inspection it was identified that some incidents were occurring in the house which had not been considered as safeguarding concerns. These had included incidents that involved one resident vocalising. After review by the provider, some retrospective safeguarding notifications were submitted to the Chief Inspector following that inspection. Since then it was notable that the amount of safeguarding notifications related to that house had increased with most involving negative peer-to-peer interactions. Such matters had been appropriately screened in line with relevant safeguarding policies with safeguarding plans put in place where necessary. Staff spoken with during this inspection were aware of such safeguarding plans. Training records provided indicated that core staff had completed relevant training in this area but some core staff were overdue refresher training. Some less regular relief staff were not listed as having completed safeguarding training. Given the safeguarding incidents that had occurred in the house since the last inspection, the inspector was informed on the current inspection a compatibility assessment for the residents in this house was being pursued.

Other than the incidents occurring in this house that had been regarded as being of a safeguarding nature, when reviewing records in the house, the inspector also

noted some incidents of a resident vocalising. It was indicated that such incidents did not impact other residents. While staff present during this inspection outlined the steps that they would take to promote positive behaviour amongst residents, other incident reports reviewed did suggest challenges in this area. Most notably, there had been one incident that had occurred in January 2024 where a staff member had locked themselves into the staff office due to the presentation of a resident. There was some information on reactive strategies to adopt with this resident if needed but this was dated from March 2020. The inspector was informed that this resident did have a positive behaviour support plan that was no longer active and that the reactive strategies for the resident were reviewed during a periodic service review (PSR). A note of the most recent PSR meeting from earlier in February 2024 was provided following the inspection.

This indicated that reactive strategies for this resident were discussed but that these needed to be revised. During this PSR it was indicated that the resident needed a low arousal space that they could access, which was found to be provided for during this inspection. However, the PSR also indicated that staff needed further training in positive behaviour support and Autism. Outside of this PSR, the same resident had also received some additional multidisciplinary input. Another note of a recent meeting related to the resident referenced that additional training in particular communication methods was needed to support staff when interacting with the resident. It was notable that such communication methods were referenced in the reactive strategies information from March 2020. Training records provided though did indicated that core staff had been provided with relevant training in de-escalation and intervention but that some core staff were overdue refresher training in this area. In addition, as referenced earlier in this report, the provider had ensured that the relevant resident was provided with one-to-one support from a dedicated staff member when present in the house. This was in keeping with the needs of this resident.

Supporting the needs of residents can be contributed to in other areas also. This includes ensuring that residents are appropriately supported to access the community and to maintain relationships with relatives. The residents in the house visited were supported to keep in contact with their family and a car was available to facilitate access to the local community. However, one resident did tell the inspector that sometimes residents could not go out if staff on duty could not drive. A similar issue had been raised in a questionnaire that was received as part of the July 2023 inspection. This was queried with management of the centre on the current inspection who indicated that while most core staff for the house were licensed to drive the house's car, not all staff were. This had resulted in instances where no licensed staff drivers were present in the house but it was stressed that this was rare. The inspector queried what alternative options were available for residents to leave the house if they wanted to in such a scenario. In response it was suggested that residents could walk into the town where the house was located or that they could get a taxi which would be paid for by the house kitty. Despite this, a staff member spoken indicated that in the event that no licensed drivers were on duty residents "would be stuck in the house". The same staff member also stressed that such instances were rare.

Aside from this, medicines management was also reviewed during this inspection. In the PAR response that had been received from the provider in September 2023, it was highlighted that there been a number of medicine errors occurring in the house visited during this inspection. It response to this it was indicated that a review meeting was to take place and the inspector was informed that this had happened. However, when reviewing incident reports in this house it was observed that the rate of medicine errors occurring in this house had increased since the September 2023 PAR response. It was acknowledged that such medicine errors involved documentation or counting errors which ultimately did not adversely impact residents. Records provided also indicated that, while one staff member was overdue refresher training, staff had completed relevant training in medicines management. Such training was delivered in person by a community nurse. The inspector was informed that depending on the time of week, this community nurse would be contacted in the event of medicine error occurring. While noting the reasons given for this, it was unclear if this fully complied with the provider's medicines management policy which indicated that a medical practitioner was to be contacted. The policy provided had not been reviewed since June 2020. A separate local medicine management policy document was also in place which indicated that a general practitioner was to be contacted for medicine errors. This local policy though had not been made specific to the house visited during this inspection.

Regulation 13: General welfare and development

A questionnaire provided as part of the July 2023 inspection referenced that in one house some staff could not drive so residents could not go on outings. This was queried at the time and it was indicated that most staff working in the house were licensed drivers and that there was no record of an instance where a resident could not attend an activity. The same house was visited during this inspection where it was indicated that there could be times when no licensed staff would be on duty to drive the house's car. It was stressed that such instances were rare and that alternative options were available if needed. However, based on the comments of one staff member and one resident during the current inspection, there did not appear to be an awareness of such options. This could limit residents' ability to avail of the local community and particular activities.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The rate of medicine errors in the house visited during this inspection had increased since September 2023. Depending on the time of the week a community nurse would be contacted in the event of medicine error occurring. It was unclear if this fully complied with the provider's medicines management policy which indicated that

a medical practitioner was to be contacted while a local medicine management policy document indicated that a general practitioner was to be contacted for medicine errors. This local policy though had not been made specific to the house visited during this inspection.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There was some information on reactive strategies to adopt with a resident to promote positive behaviour but this was dated from March 2020. A note of a February 2024 PSR indicated that such strategies needed to be revised. The same PSR referenced staff needing training in positive behaviour support. Some incidents did suggest challenges in supporting this resident to engage in positive behaviour. One such incident involved a staff member locking themselves into the staff office in response to the presentation of the resident. This indicated that the staff member was not equipped with the necessary skills and knowledge to support the resident around their behaviour.

Judgment: Not compliant

Regulation 8: Protection

There had been an increase in safeguarding incidents occurring in the house visited since the previous inspection. Most of these involved negative resident interactions and, while safeguarding plans were in place, it was indicated that a compatibility assessment for residents in the house was being pursued. Some less regular relief staff were not listed as having completed safeguarding training.

Judgment: Substantially 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 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for No.4 Fuchsia Drive OSV-0004478

Inspection ID: MON-0042858

Date of inspection: 16/02/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider will ensure that the whole time equivalent of the social care worker staff is in line with the statement of purpose. We will continue to progress the recruitment and appointment of a full-time social care worker post and review the roster to determine how best to fill the part time gaps in the roster.	
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 has in place a supervision programme with dates scheduled for 2024. The Person in Charge will ensure all staff's first supervision for 2024 is completed by 30 May 2024. The Person in Charge will ensure where staff are in need of refresher training in such areas as safeguarding positive behaviour support and medication management and that these bookings are be made by 30 April 2024 as the next quarter's training places are made available by the training department. The core staff team are scheduled to receive training in autism on 11 April 2024. The core staff team will be scheduled for LAMH training by 30 July 2024 however they will attend this training on a phased basis throughout the remaining year as it is not possible for the entire core team to attend the same full day training on the same day.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider has ensured that the incident log book is now up to date with all incidents signed off by the Person in Charge.

A team-meeting schedule is now in place for 2024 and that the PIC will ensure that staff are advised that this is the forum for issues of concern to be raised and addressed as a Team in the first instance and elevated to Senior Management from there if necessary. The topic of safeguarding remains a standing agenda item at staff and resident meetings. In addition, the designated officer will attend the next scheduled team meeting at this house to discuss safeguarding policies and procedures with the staff team in the house inspected by 30 April 2024.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Registered Provider has now reviewed and updated the Region's policy on person-centered medication management. It is now being printed and will be available in the Centre in April 2024.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The Registered Provider has ensured that the Person in Charge has created a written centre-based protocol for staff to follow where the staff on duty do not drive. This has information on taxis that the persons supported can avail of.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Registered Provider will ensure that staff are aware that in accordance with the existing medication policy and the updated medication policy, the process is to contact a medical practitioner in the first instance in the event of a medicine error.
The staff team will be advised that in the first instance, their immediate action will be to contact a medical practitioner after which they can contact the community nurse for any advice, if necessary.
The Local Medication Management Policy will be made specific to the houses in the Centre.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge will ensure that personal behavioural support plans for the relevant residents in the house inspected, remain under review through the periodic service review process. This is an ongoing process during 2024. All actions that arose at the PSR dated February 2024 were actioned following this meeting and continue to be actioned in March 2024 including updating the Reactive Strategy and staff training.

The Person in Charge will ensure that there is written evidence in place that set out the induction that staff receive from the person in charge/team leader and or the red dot staff member when working at this house. This will include relief staff that are used occasionally at the house particularly during times of unexpected staff leave.

The Person in Charge has requested that the core staff team are scheduled for training Positive Behaviour Support by 30 July 2024.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Person in Charge will ensure that all staff are up-to-date in training in safeguarding.

Three relief support workers had worked at the house for a small number of shifts during a period of exceptional unexpected leave in December 2023 and January 2024. Two of these staff members have since completed this training and the third due to complete this training by the 31 March 2024.

Five of the permanent staff team were outside of their refresher timelines in adult safeguarding. The Person in Charge will ensure that this training is completed by the 31 March 2024.
The Person in Charge continues to work closely with the multi-disciplinary team in assessing the needs and the compatibility of the residents.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	19/03/2024
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	19/03/2024
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Substantially Compliant	Yellow	30/06/2024

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
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	30/07/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/05/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2024
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the	Substantially Compliant	Yellow	30/04/2024

	care and support provided to residents.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30/04/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/04/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to	Not Compliant	Orange	30/05/2024

	behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/05/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/03/2024
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	31/03/2024