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:	Woodlands
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	15 November 2022
Centre ID:	OSV-0004891
Fieldwork ID:	MON-0038389

About the designated centre

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

In this centre, a service is provided to four residents who, while of a younger age profile are all over the age of 18 years. Three residents receive an integrated type service where the support provided includes a range of in-house and community based programmes. In addition, a day service is provided on-site to a resident who avails of a respite service. Wheelchair accessible transport is available to residents to facilitate their outings and access to community activities. Each resident presents with a broad range of complex needs in the context of their disability and, the service aims to meet these needs. The premises is a bungalow type residence with all facilities provided at ground floor level. Three residents have their own ensuite bedroom and share communal, dining and, kitchen facilities. The house is located in a suburb of a large town a short commute from all services and amenities. The model of care is social and the staff team is comprised of social care and support staff under the guidance and direction of the person in charge. Given the assessed high needs of the residents each resident has one to one staff support during the day. Night time staffing comprises of a sleepover staff with the addition of a waking staff when all three residents are in receipt of a residential service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 15 November 2022	10:00hrs to 17:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

Based on what the inspector observed, read and discussed residents received the support that they needed to enjoy good health and a good quality of life. It was evident however, that there had been a period since the last HIQA (Health Information and Quality Authority) inspection of this service that gaps had arisen in the management and oversight of the service provided. While there was no evidence that this had directly impacted on residents and it was evident that this was now being addressed, the provider did need to ensure that the improvement evidenced was sustained and the centre was consistently and effectively managed.

Four residents receive support and care in this service but a maximum of three residents can be accommodated at any one time. This is facilitated by the provider as a respite service is provided to one resident while another resident is at home with family. All four residents were present on the day of inspection as the resident who is provided with a respite service is also provided with a day service on site. In the context of their disability and primary diagnoses all four residents have high support needs and are dependent on support from staff to meet all of their activities of daily living. Residents assessed needs include communicate differences and residents communicate by for example gesture, facial expression or behaviour: this was how residents individually interacted with the inspector during the day.

On arrival at the house it was evident that controls were in place to monitor the wellbeing of visitors such as the inspector to the house to reduce the risk of inadvertently introducing infection such as COVID-19. There was prominent signage advising visitors of this. All areas of the house were visibly clean. Based on feedback from staff and the findings of an internal review the person in charge had recently secured a colour-coded cleaning trolley for staff. This equipment was reported to have been well received. The design and layout of the house supported the isolation of residents if necessary as three bedrooms had ensuite sanitary facilities. The provider had plans in progress to extend the premises and to improve the facilities provided to residents. However, in the interim improvement was needed to the bedroom provided for one resident. This room presented as a functional but not a quality, personalised space. Repairs and repainting were needed in some areas in particular circulation areas.

The inspector saw that in response to the high support needs of the residents the provider had good staffing levels and arrangements in place and these were altered as needed to reflect the occupancy and needs of the residents. There had been some turnover of staff and staff members had recently been recruited. The provider did need to review its procedures for evidencing what training was completed by new staff members before they commenced work in the designated centre.

The inspector noted that staff were attentive to the needs of all four residents and while busy there was a pleasant and relaxed atmosphere in the house. The care and support observed was as set out in the personal plan. For example, the provision of

meals of a modified texture and supporting residents to maintain muscle strength, flexibility and mobility. Staff were attentive to the medical and healthcare needs of the residents. On the day of inspection staff members supported a resident to revisit their general practitioner (GP) as staff were not assured of the effectiveness of the treatment initially prescribed. A physical therapist provide on-site therapy on the morning of inspection. However, there was scope to improve aspects of the personal plan.

The complexity of residents needs did not limit the quality of life that residents enjoyed in this centre. The inspector saw that staff members ensured residents were comfortable and dressed appropriately for the weather prior to going to the GP and for walks in their local community. Two residents supported by two staff members left for a swimming session in the late afternoon. The routines in the house were individualised such as the time that residents got up at, had their meals and rested for periods during the day. Residents had ongoing contact with family and home as appropriate to their individual circumstances.

The inspector did not meet with any resident representative. Staff maintained a record of family contact and kept families updated as requested in relation to any changes and concerns arising. Families were also aware of and used the provider's complaints policy as necessary. The person in charge said that day-to-day feedback from families indicated a good level of satisfaction with the service. However, it was discussed with the person in charge how the process for obtaining feedback from families to inform the annual review of the service could be strengthened or altered, for example if families were reluctant to complete a formal questionnaire.

In summary, this was a good service that was focused on providing each resident with a safe, quality service and a good quality of life. However, as referred to in the opening paragraph of this report there were findings from this HIQA inspection that indicated gaps had arisen in the management and oversight of this service. The inspector was assured by these HIQA inspection findings that the matters arising were being addressed by the recently appointed person in charge. However, improvement was still needed in some areas and the provider needed to ensure that this gap in oversight did not reoccur.

The next two sections of this 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

Management systems were now in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. The centre presented as adequately resourced and the provider had plans to improve the facilities provided for residents. However, as stated in the opening section of this report it was evident

that gaps in management and oversight had arisen in what had been a consistently well managed service. While the inspector was assured that this was now being addressed, improvement was still required in a number of areas such as in fire safety, staff training, personal planning and, the premises.

The person in charge described to the inspector factors that had potentially contributed to this gap in management and oversight. For example, there had been a change to the role of person in charge, deficits had arisen in staffing and in the social care worker role, a role designed to support the person in charge in the day-to-day management and oversight of the service. The evidence to support this gap in management and oversight was evident from the substantial action plan that had issued from the internal quality and safety review completed in July 2022 and from an infection prevention and control audit also completed in July 2022. Items not addressed at that time were an open complaint, the completion of the annual service review, oversight of risks and restrictive practices and, consistent monitoring of the effectiveness of the centres infection prevention and control arrangements.

Gaps in the management structure were now addressed and the person in charge was satisfied as to the capacity and effectiveness of the management arrangements in place. For example, two social care workers were in place and the recruitment of staff to fill vacancies meant that the social care workers could attend to their assigned management duties. The person in charge had another designated centre to manage but endeavoured to be present in this centre at least two days each week. The inspector saw that the person in charge convened and chaired regular staff meetings. There was good staff attendance at these meetings, good discussion and feedback to staff where improvement or learning had been identified. The person in charge confirmed that they had very good access and support from their line manager. The person in charge had since their appointment implemented good systems of oversight such as for the oversight of incidents and risks. Formal staff supervisions had been completed with all staff members.

Therefore, it was evident from these HIQA inspection findings that the person in charge was effectively addressing the gaps in oversight that had arisen and was effectively monitoring and overseeing the service. The person in charge was progressing the internal quality improvement plans. Other internal reviews supported good practice for example in the management of medicines and the management of residents' personal assets. However, improvement was still needed in some areas and the provider needed to ensure and provide assurance that suitable arrangements would be in place going forward for the consistent management and oversight of this service.

There had been some turnover of staff. Staff members had been recruited and the provider had plans to enhance the skill-mix further with the imminent addition of nursing skill-mix to the staff team. However, the provider did need to review and put in place systems that evidenced the training completed by new staff members before they commenced work in the centre. The provider also needed to ensure that it had suitable arrangements in place for staff to receive timely refresher training.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. Since their appointment the person in charge had implemented effective systems of management and oversight. The person in charge had and was in the process of addressing quality improvement plans that had issued from internal reviews of the quality and safety of the service.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements reflected the number and the high assessed needs of the residents. The person in charge told the inspector that while it had been challenging the required staffing levels had always been maintained; the provider had recruited staff to fill vacancies that had arisen. Each resident had 1-to-1 staff support by day and two staff members were on duty each night. The night time staffing arrangement was altered as needed in response to individual resident needs. The provider was in the process of developing the staff skill-mix with the addition of a nursing staff. There was a planned and actual staff rota in place that showed the staff members on duty by day and by night and their allocated resident responsibilities. There was scope to improve the format of the staff rota and this was highlighted to the person in charge.

Judgment: Compliant

Regulation 16: Training and staff development

The system in place for evidencing the completion of training by newly recruited staff members was not sufficient to demonstrate what training they had completed prior to commencing work in the centre. For example, training in safeguarding and infection prevention and control. While the person in charge said that there was a core range of training that was completed during the staff induction process there was no documentary evidence to support this. In addition, the provider needed to ensure that it had suitable arrangements in place for delivering fire safety training. The person in charge said that this had recently been highlighted to management. Four existing staff members were overdue refresher training in fire safety. A number of staff members had yet to complete a training tutorial on how to fit-test an FFP2 face mask.

Judgment: Substantially compliant

Regulation 23: Governance and management

What was evident from these inspection findings was a gap had arisen in the management and oversight of this service. Substantial quality improvement plans had issued from the most recent internal quality and safety review and from an infection prevention and control audit. Items that had not been satisfactorily managed included the resolving of an open complaint, timely completion of the 2021 annual service review and the review of an outbreak of infection that had occurred in April 2022. Based on these inspection findings it was evident that the person in charge had since their appointment progressed these quality improvement plans. For example, the complaint had been resolved and the infection outbreak review had been completed. However, these improvement actions had been delayed and there was still work to be done. The impact of this gap in management and oversight was also evident in the somewhat lower level of compliance with the regulations when compared to previous inspections of this service. The provider needed to ensure that the progress made would be sustained and that the management systems in place would ensure that the quality, safety and appropriateness of the service was consistently and effectively monitored.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The contract for the provision of services had been signed by a representative of the provider but not by the resident or their representative where for example the resident was not able to give or indicate their agreement with the contract as provided for in the regulation.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure was prominently displayed. The person in charge had progressed and resolved two complaints that had been received. A clear record was maintained of the actions that were taken to resolve the complaints, of the feedback that was provided to the complainants and their satisfaction with the actions taken. The person in charge had a plan for monitoring the effectiveness of these improvement actions so that there was no reoccurrence.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had all of the policies to be maintained in the designated centre as outlined in Schedule 5 of the regulations. Soft copies of these policies were available to staff. Hard copies of core policies such as the risk management policy were also available. However, a small number of these policies had not been reviewed within the past three years.

Judgment: Substantially compliant

Quality and safety

This was a person-centred service where the provider had the arrangements needed to meet the complex needs of the residents so that residents enjoyed the best possible health and a good quality of life. There was scope however, to improve areas such as personal planning, fire safety and the facilities provided to all residents.

The inspector saw that staff members on duty were attentive to residents and confident as they provided care and support to residents. The person in charge and staff spoken with were evidently attuned to the needs and wellbeing of each resident. For example, the inspector noted that one resident did not appear to be in the best of form while another resident presented as a little tired. Clear rationales for this were provided. The support and care observed reflected what was read in records such as risk assessments and the personal plan. For example, ensuring residents were supervised and had assistance at mealtimes and had periods of rest from seating and positioning devices.

The evidence base of the care and support provided by staff was informed by regular and consistent access to clinicians and specialist services as appropriate to the specific needs of the residents. For example, as discussed in the opening section of this report staff monitored resident health and wellbeing and the effectiveness of prescribed treatments and sought further GP advice if they had concerns. There was consistent monitoring of the suitability of the equipment that residents needed for their safety and wellbeing. However, the personal plan was a sizeable and fragmented record and the inspector was not robustly assured as to how it actually guided daily practice.

The personal plan included the plan for responding to behaviours that challenged or posed risk to the resident themselves or others. The plan reviewed by the inspector had been reviewed following the findings of the last HIQA inspection and the person

in change had recently sought a further review. The positive behaviour support plan clearly underlined the significance of behaviours as a means of communication given the complex needs of residents. For example, to communicate pain.

The person in charge had implemented good risk management systems based on the providers risk management procedures. The inspector reviewed the risk register and found that the risks identified and their management reflected the assessed needs of the residents and matters arising in the service. For example, the person in charge had open risk assessments for manual handling and people moving needs and for the outstanding staff training referred to in the previous section of this report. Controls included the fact that staff did not lone work in this service. The management of risk was dynamic and responsive to any incidents or accidents arising and timely corrective actions were taken as needed such as referral to the MDT and the review of equipment supplied.

The provider had the required fire safety measures in place such as a fire detection and alarm system, emergency lighting and doors fitted with self-closing devices designed to contain fire and its products. The person in charge had identified the need for improving both the recording of fire evacuation drills and the scheduling of drills to ensure all staff participated in a drill. However, there was still a need for better oversight of the arrangements for testing the evacuation procedure.

Regulation 11: Visits

Reasonable controls were in place to ensure that preventable infections were not accidentally introduced to the centre. The person in charge said there was good co-operation with these controls as the objective to protect residents and staff was understood. Residents had good access to family and home and family were free to visit the centre as they wished.

Judgment: Compliant

Regulation 17: Premises

The provider was progressing plans to extend the premises and improve the facilities available to residents. However, in the interim there was much scope to modify and improve one residents bedroom. This room had previously been used as a sensory room and fitted sensory equipment had not been removed. This reduced the amount of available floor space and dictated the position of the residents bed. This in turn narrowed the space available to the resident and staff as they entered the room. Therapeutic equipment for general use by residents was also stored in the corner of the bedroom. The room presented as functional but not welcoming.

Overall the house was well-maintained. However, circulation areas in particular were

in need of some minor repairs and repainting.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The person in charge had implemented good risk management systems based on the providers risk management procedures. The identified risks and the controls to manage the risk were centre and resident specific. The management of risk was dynamic and responsive to any incidents or accidents arising and timely corrective actions were taken to ensure resident safety.

Judgment: Compliant

Regulation 28: Fire precautions

There was a requirement for the provider to review its arrangements for providing fire safety training for staff; this is addressed in Regulation 16. The records of the drills completed however, indicated staff understood the evacuation procedure and could evacuate residents in planned and unplanned situations. Newly recruited staff had participated in a recent simulated drill. However, while the drills were convened to replicate different scenarios such as residents being in bed, and overall good evacuation times were recorded, none of the drills completed this year had tested the ability of 2 staff (minimum staffing levels) to evacuate all three residents.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The providers policy on the management of medicines was overdue review: this is addressed in Regulation 4. However, on a day-to-day basis there were procedures that supported safe practice. For example, the prescription record was legible and the record of medicines administered by staff reflected the instructions of the prescription. Where it was necessary to administer medicines in an altered format (crushed) this was indicated on the prescription sheet by the prescriber. There were protocols for the administration of as needed medicines and for the occasions when residents refused to take their prescribed medicines. Staff monitored the effectiveness of prescribed treatments. Medicines management practice was audited. Medicine related incidents were monitored and analysed by the person in charge with no concerning patterns arising. Each residents ability to manage their

own medicines or not was assessed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector was not assured as to how robustly the personal plan guided the support and care provided. For example, a plan seen stated that a resident was to be weighed monthly but there was no weight record in the plan from November 2021 to October 2022. The resident had maintained their body weight indicating their nutritional plan was followed. In addition, while the personal plan included the resident's personal goals and objectives there was no clear plan or timeframe for progressing these goals. There was strong multidisciplinary (MDT) input into the care provided but how the MDT review of the effectiveness of the personal plan was facilitated was unclear.

Judgment: Substantially compliant

Regulation 6: Health care

There was clarity on each residents healthcare needs. There was robust documentary evidence of consistent engagement with community and hospital based clinicians and services that reflected the complex needs of the residents. Staff monitored resident wellbeing and the effectiveness of prescribed treatments and ensured residents had access to follow-up medical review and care as needed.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour support plan had been updated since the last HIQA inspection. There were a range of interventions in use that met the benchmark for a restrictive practice. Oversight of the use of these interventions was multi-disciplinary. A member of the MDT had provided a face-to-face session for staff on restrictive practice. The review of incidents, any feedback received and monitoring records maintained by staff supported the ongoing need or not for some interventions. Interventions were removed once the data collated indicated their use was no longer needed. Interventions were at times the least restrictive intervention. For example, the use of alarms to alert staff if a resident was getting out of bed, the

use of profiling beds and protective floor mats rather than using bedrails.

Judgment: Compliant

Regulation 8: Protection

The provider had safeguarding policy and procedures that were in date. The contact details of the designated safeguarding officer were prominently displayed. The provider responded to any concerns that were raised about the quality and safety of the service and fulfilled its reporting responsibilities to relevant bodies such as HIQA. Given the complex needs of the residents and the limitations for self-care and protection the person in charge described how they observed staff practice and observed how residents responded to each staff member so as to monitor the quality and safety of the service. The person in charge reviewed tools such as body maps (for recording any injuries) in their review of incidents and accidents. Safeguarding, staff responsibilities and reporting structures were discussed at a recent staff team meeting and refresher face-to-face safeguarding training was scheduled for all staff.

Judgment: Compliant

Regulation 9: Residents' rights

Given the high support needs of residents this could have been a service based on routine. However, while residents may not have been readily able to express their choices and preferences the care and support observed was individualised to each resident. The role of behaviour was recognised as a means of communicating whether a resident consented or not to the support to be provided; there were protocols for responding to this. Staff members and family advocated for residents for example in relation to accessing the services and equipment that they needed. Disability did not limit the opportunities available to residents and good provision of suitable transport was available for residents to access community based amenities. Staff were noted to be mindful and respectful of resident privacy and dignity as they provided any support and care needed.

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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Woodlands OSV-0004891

Inspection ID: MON-0038389

Date of inspection: 15/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC will ensure that training completed by new staff is demonstrated in a system that is clearly identifiable and evidenced in a matrix separate from the matrix in use for current staff. (Planned completion 31/12/2022) The PIC will ensure that staff members that require training in fit testing an FFP2 mask is complete. (Planned completion 31/12/2022) The Provider will ensure that the arrangements in place for delivering fire safety training will be reviewed to ensure that staff have the required fire safety knowledge and skills to react correctly in the event of a fire. • Training dept. are in the process of procuring Fire Safety training for the organization, with a planned implementation date of new training process from 30/01/2023. • Training dept. and SMT will review training to be completed by new staff members, prior to commencing work with the organization, and ensure the suite of training is comprehensive and appropriate to support them in their roles; and that an efficient system of including said trainings on their training records, at the onset of their employment. (Planned completion 28/02/2023)	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Action plans from recent internal audits, and this compliance plan will be completed within prescribed time-lines. • The PIC will continue to progress and complete in full, quality improvement plans already in progress. Thereafter, the PIC will continue current level of oversight and governance within the centre.	

• Administration time assigned to local leads in the team will be protected going forward, and additional recruitment will be facilitated to ensure appropriate relief cover within the team, to prevent impact on this time. (Overall Planned completion: 31 March 2023)

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • The PIC will ensure that the current contracts for the provision of services are reviewed and signed by the resident or their representatives; or where this is not possible despite efforts, a note will be added to the contract to reflect this. • To ensure compliance going forward, the PIC will ensure that the terms on which the resident will reside in the center are reviewed annually and provided to residents/ representatives. (Complete)

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: In order to attain compliance with Regulation 4, the provider has commited to ensuring outstanding polices will be reviewed and implemented by the outlined timeline below: • Medication management policy • Positive Behaviour Support • Good practice procedure in the handling of personal assets of people who use our service. (Overall planned completion 30/04/2023)

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The registered provider will ensure the premises of the designated centre are designed to meet the aims of the service and the needs of the residents. This will be ensured with • The removal of general use equipment has occurred and alternative storage has been sourced. • Sensory equipment will be removed to ensure the residents bedroom is welcoming and appropriately decorated. • The PIC has requested the repainting and minor repairs to be completed in circulation areas to ensure the premises presents in good condition. (Overall completion 28/02/2023)

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The PIC will ensure a fire drill is completed, that will test the center's evacuation plan with minimum staffing (2 staff) and maximum residency to ensure a timely evacuation is achievable. (Complete) • The PIC will ensure to provide oversight of drills going forward to ensure the staff competence in an emergency situation. The PIC will implement a fire drill schedule to reflect a range of real life scenarios that demonstrate everyone can be evacuated safely

within the safe time and staff are knowledgeable of procedure.
• The PIC will ensure the drills are routinely practiced, repeated if issues arise and all staff participate in fire drills. This will be reviewed by the PIC quarterly.
(Overall completion 30/03/2023)

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 Provider and PIC will ensure all staff are trained effectively in personal planning.
• The PIC in partnership with keyworkers will ensure personal plans reflect the residents needs and that goals set, are measurable and achievable within stated timeframes.
• Oversight of progress will be maintained by the PIC through regular review with key workers on a six-monthly basis minimum.
• The PIC will ensure the required health interventions and multidisciplinary recommendations are reflected in the personal plans.
• The PIC will subject the plans to frequent review to assess if development or changes have occurred to identify if the plans are effective or if further supports are required.
• The PIC will ensure changes to plans are evidenced with relevant rationale and agreed timescales.
• The filing system in relation to individuals' plans/ health care assessments and daily recording will be reviewed and stream-lined.

(Overall planned completion 30 June 2023)

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
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.	Substantially Compliant	Yellow	28/02/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	28/02/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Substantially Compliant	Yellow	31/03/2023

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	12/12/2022
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	30/03/2023
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	30/04/2023
Regulation 05(6)(a)	The person in charge shall ensure that the	Substantially Compliant	Yellow	30/06/2023

	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 multidisciplinary.			
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	30/06/2023