Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Dun Aoibhinn Services Cahir
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	22 August 2023
Centre ID:	OSV-0005066
Fieldwork ID:	MON-0039359

About the designated centre

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

Dun Aoibhinn Services Cahir is a designated centre operated by Brothers of Charity Services Ireland CLG. The designated centre provides a community residential service for up to eight adults with a disability. The designated centre consists of two houses located within a close proximity to each other in a town in County Tipperary. The first house is a two storey house which comprised of a kitchen/dining room, living room, four individual bedrooms (two of which were en-suite), sensory room office and staff sleepover room. The second house is also a two storey house which comprised of a living room, kitchen/dining room, office, four individual bedrooms (one of which was en-suite) and a staff sleep over room. There are gardens to the rear of both houses for the residents to avail of as they please. The centre is staffed by the person in charge, staff nurse, social care workers and care assistants. The staff team are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 22 August 2023	10:15hrs to 17:45hrs	Conan O'Hara	Lead
Tuesday 22 August 2023	10:15hrs to 17:45hrs	Tanya Brady	Support

What residents told us and what inspectors observed

This was an unannounced focused risk-based inspection carried out by two inspectors over one day. The inspection was completed to determine progression levels by the registered provider against actions set by them to come into compliance with Regulations previously identified as requiring improvement during an inspection completed in November 2022.

Since the last inspection, the provider had completed a planned reconfiguration of their services. The provider increased the capacity of this centre from one unit providing a service to four residents to two units for eight residents. This was the first inspection of the centre in its current configuration. Over the course of the inspection, the inspectors had the opportunity to meet with seven of the eight residents and visited both homes.

In the first unit, the inspectors met with three of the four residents. One resident was attending day services and staying with relatives in line with their routine and personal plan. On arrival, the inspectors were greeted by one resident who welcomed them to their home. The inspectors met with two residents, one was having a cup of tea and watching TV and the other was preparing for their day. One of the residents was supported to pack their belongings as they were going to visit family. Later in the morning, the third resident, who was accessing the community and out for a walk, was observed returning home and spending time in the sitting room. The staff present in this house were available to support residents in their daily activities while encouraging them to make choices such as what to watch on television or to go and select items to bring with them in their bags when going out.

In this house, the previous inspection identified that the staffing arrangements in the centre and the supports in place to meet the need of one resident required significant review. From a review of rosters and the personal plans, this had been addressed with enhanced levels of staffing support present and consistency in the staff present in the centre.

The inspectors completed a walk around of this home accompanied by a staff member. The designated centre comprises of four individual resident bedrooms (two of which were en-suite), staff bedroom, office, shared bathroom, sensory room, sitting room, utility room and an open plan living, dining and kitchen area. In general, the house was observed to be well-maintained and decorated in a homely manner with residents' personal possessions and photographs throughout the centre. There were areas of chipped and damaged paint observed which required review.

The inspectors also observed areas which required attention including poor ventilation in one bathroom. In addition, ongoing issues remained with a fence surrounding the property and potholes present in the gravel surrounding the centre. The potholes presented as a hazard to residents and accessibility issues for one

resident with limited mobility. These ongoing issues had been identified on previous inspections and internally by the provider. While the issues had not been fully addressed, the provider had completed some ongoing running repairs and informed inspectors of a long term plan to address same.

In the afternoon, the inspectors visited the second house. The inspectors were able to complete a review of documentation and discussions with staff prior to residents returning home. All four residents attend a formal day service. The inspectors observed the four residents returning from their day service and appearing happy to be home, greeting each other and staff and settling in for the evening. The four residents unpacked their bags, returned their personal plans and files to the office and took responsibility for their belongings when they returned home. The residents showed the inspectors around their home and discussed where they were from, people important to them and the activities they enjoyed. One resident spoke of their achievement in the Special Olympics and the medals they had on display, another resident spoke of family and indicated family photographs on display. A resident told the inspectors about sports they liked to watch and spoke of supporting a family member at soccer games locally with their peers.

However, the staffing levels in this house were observed to be negatively impacting on the lived experiences of residents and the ability of the staff to implement support plans. The four residents were supported by a lone staff member day and night. This meant that the residents had limited opportunity for activities in the evening and weekends due to the identified supervision needs of the residents. For example, the residents had to partake in group activities together at evenings or weekends in order for them to be carried out. If one resident did not wish to partake in an activity then no residents could attend. The staffing arrangements also required the four residents to leave their home at weekends to allow for a change in the staff team as per the roster. In addition, due to the identified and assessed for risks when residents were left together without supervision and support, the staff team had to direct residents to remain in selected areas of their home in order to ensure their safety. The staff members discussed with the inspectors that this might mean pausing an activity residents were involved in asking them to move in order that the staff member could provide personal care to one individual. The provider had self-identified the need for additional staffing and had submitted a business case to their funder, however the four residents remain with support from a lone staff member at the point of inspection.

The inspectors completed a walk around of this house accompanied by a staff member and the person in charge. The designated centre comprises of four individual resident bedrooms (two of which are en-suite), staff bedroom, office, two shared bathrooms, sitting room, utility room, and kitchen/dining area. The house was observed to be decorated in a homely manner with residents' personal possessions and photographs throughout the centre. The house did require a number of premises works all of which were self identified by the centre management team at the point of the house becoming part of this centre. These included internal and external painting, replacement flooring throughout the premises and the need to upgrade/replace some windows and patio doors. The inspectors reviewed the costed and time-bound action plan in place to address

same.

Overall, the residents appeared comfortable in both homes and the staff team were observed supporting the residents in an appropriate and caring manner. The inspectors found that the provider had responded to the findings of the previous inspection and addressed the areas for improvement. For example, additional staffing had been put in place in one house and appropriate supports were in place to meet the needs of all residents who lived there. However, despite the good quality of care and support offered by the staff members when on duty the inspectors found that the staffing arrangements in the second unit negatively impacted on the staff ability to provide residents with positive individualised experiences, to meet their safeguarding and positive behaviour needs and required significant improvement.

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

Capacity and capability

The inspectors found that there was a clearly defined management system in place which had identified lines of authority and accountability. The local management team had reviewed the service provided throughout the centre and were striving to ensure it was safe, consistent and appropriate to residents' needs. Inspectors acknowledge that the provider has self-identified areas of improvement and there were plans in place to address. However, some plans were resource dependent. While, areas identified for improvement in the previous inspection in one home, had for the most part been addressed, the staffing levels in the second house required improvement as they were negatively impacting on the quality of life of the residents in the house.

The centre was managed by a full-time, suitably qualified and experienced person in charge. There was evidence of regular quality assurance audits taking place to ensure the service provided was assessed and monitored. However, at the time of inspection not all areas had been fully reviewed or assessed. For example, a number of risk assessments had not been completed. Improvement was also required to ensure the designated centre was appropriately resourced to ensure the effective delivery of care and support.

For the most part, the areas identified as requiring improvement in the second house were linked to the low levels of staffing. At the time of inspection, the staffing levels did not meet the assessed needs of the residents at all times. This was self-identified by the provider. For example, as stated, in the second house the four residents were supported by a single staff member. One resident was assessed as requiring one-to-one staffing support in the community and general supervision when at home. This meant that other residents had limited choice and control in

relation to individual activities on the evenings and at weekends. The low staffing arrangements also meant that positive behaviour support plans and safeguarding plans could not always be implemented due to the lone working. This is outlined further under Regulation 7: Positive Behavioural Support and Regulation 8: Protection.

Overall, the staffing levels in place were not in line with this resident's needs and negatively impacted on the four residents lived experience of their home.

Regulation 15: Staffing

The inspectors found that while an assessment of required staffing levels had taken place, the staffing levels on the day of the inspection did not ensure residents were safe, had their care and support needs met and respected their rights at all times. These findings are reflected in high levels of non-compliance with the regulations as outlined in the report.

The person in charge maintained a planned and actual roster. The inspectors reviewed samples of the roster and found that in both houses there was a core staff team in place which ensured a measure of continuity of care and support to residents. At the time of the inspection, the centre was operating with four whole time equivalent vacancies which was managed through the current staff team, the use of agency and relief staff. The inspectors were informed that the provider had successfully recruited to fill two whole time equivalent posts that had been vacant and newly recruited staff were currently going through the provider's on-boarding process. In addition the other positions currently vacant were ready to be advertised.

Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner. The staff who spoke to the inspectors were found to be familiar with residents' care and support needs and to be motivated to ensure that each resident was happy and safe living in the centre. The staff team presented as knowledgeable in relation to the individual needs of the residents. They outlined different supports required and how they ensured these were used such as symbol based communication systems, management of complex eating, drinking and swallowing needs or physical prompting and guidance systems. The staff team in one house had the scope to use their time to ensure household tasks were completed in a manner that did not prevent them from a focus on engaging and supporting the residents when they were in the house. This was not possible for the staff team in the other house.

The previous inspection found that the staffing requirements in the first house required improvement as one resident receiving one-to-one support had been assessed as requiring two-to-one support for significant parts of the day to assist with activities of daily living. The inspectors found that this had been addressed and additional staffing supports were in place. Staff spoken with noted that there had been a significant change in the support available for the resident and that this

facilitated increased activities in line with the resident's interests.

It was of concern however, that at times staff from this house were called on to provide support in the second house. For example, in administering medication or to cover shifts. This took from the consistency of care that had been put in place in the first house. The inspectors found that when staff were asked to go to the second unit to administer medication this was for example when a lone agency staff member may be on duty without the required medicines management training/qualifications. This was of particular concern as some residents in this house were prescribed PRN (as required) medicines that may be required (on short notice) while managing behaviours that challenge or if in pain and they may not receive these in a timely manner. Inspectors acknowledge this was not a frequent requirement.

In the first house, the four residents were supported by six/seven residential staff members during the day. At night, the four residents were supported by one sleepover shift and one waking night shift.

The inspectors found that the staffing levels in the second house required significant improvement. In this house, during the day the four residents were supported by one staff member. At night, the four residents were supported by one sleepover staff. While these residents did not have the same level of assessed needs as their peers they required one-to-one support for a number of aspects of personal care over the course of the day and/or to access activities of their choice. This was not happening due to poor staffing levels.

The inspectors were informed that an application had been submitted to the provider's funder for additional staffing and this was made available for review. However, the issue had been in place since this house became part of this designated centre and a new resident had moved into the home. The issue remained ongoing at the time of the inspection without a clear time line for resolution.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The person in charge reported to the Service Manager, who in turn reported to the Regional Services Manager. There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to the residents' needs. The quality assurance audits included the annual review 2022 and six-monthly provider visits. These audits identified areas for improvement and developed action plans in response. However, given the number of areas requiring assessment and review due to the new configuration of the centre some areas still required oversight and review. The local management team and person in charge were aware that areas had not yet been

fully assessed and the inspectors acknowledge that the provider had prioritised a number of areas to review initially.

As noted, the previous inspection identified that improvements were required in one unit regarding staffing arrangements and supports in place to meet one residents needs. These had been addressed in line with the provider's submitted compliance plan.

However, the inspectors found that the second house of the designated centre was not appropriately resourced to ensure the effective delivery of care and support on the day of inspection. Residents' assessed health, personal and social care needs were not being met as required due to the level of resources not being in line with those required. While the provider had self-identified that the staffing resources were not appropriate and impacted on the residents' quality of life in their six-monthly provider visits and internal audits, this remained an issue and was ongoing at the time of the inspection without a clear time line for resolution.

Judgment: Not compliant

Quality and safety

Overall, there were established management systems in place to monitor the quality of care and support provided to the residents however, as reflected above under Regulation 23 these had been prioritised and were not yet all reviewed. The inspectors found that the service was striving to provide person centred care and support. However, the staff team were not in a position to consistently implement stated procedures due to limitations on their time. Significant improvement was required in residents rights, positive behaviour support and safeguarding. In addition, some improvements were required in fire safety, risk management and the premises.

The registered provider had employed a staff team who had a kind approach in regards to the provision of care. The inspector observed that the person in charge and staff team responded respectfully to the residents at all times and were caring and familiar with their individual needs.

The inspectors reviewed a sample of residents' personal files which comprised of a comprehensive assessment of residents' personal, social and health needs. Personal support plans reviewed were found to be up-to-date and to suitably guide the staff team in supporting the residents with their personal, social and health needs. However, the behaviour management guidelines and safeguarding plans in place in one unit could not always be effectively implemented due to the staffing levels. For example, one behaviour support plan outlined that to support a resident in managing their behaviour they should be supported to go for a walk. This was not always possible due to the identified supervision needs of the other residents.

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs of the residents. The inspectors found that the two houses were decorated in a homely manner. Residents were observed to be comfortable and familiar with the layout of their homes and to independently move through their home. Residents showed inspectors areas of their homes that were personal to them and spoke of their mementos and personal items that were displayed.

The previous inspection identified a number of pot holes in the driveway and a fence in need of attention in the first house. While, these issues had been partially addressed, they remained ongoing at the time of this inspection. The inspectors also observed a mal-odour in one bathroom which required attention. In addition, there were areas of chipped and damaged paint and flooring which required review. The inspectors acknowledge that the provider has a long-term plan in place to meet the premises actions related to this home.

In the second house, a number of areas required attention. For example, the flooring throughout the house required replacement, windows required replacement and painting (both internally and externally) was needed. In addition furniture that was worn needed replacement. Some of the identified areas were already underway and residents were overheard asking the person in charge about when their new beds were to be delivered. Other areas had been costed and quotes had been obtained, all areas observed by inspectors had been self-identified by the provider and plans were in place to address same.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The inspectors reviewed the risk register and found that not all risk assessments were up-to-date and reflective of the controls in place.

In one house a number of risk assessments had not been reviewed since the house had become part of this designated centre and there had been a change in the residents who lived there. For example one risk assessment referenced use of the bath, however, no bath was in the house. Another risk assessment related to an individual and management of seizures at night, the control measures were not reflective of the resident's current presentation nor had these been reviewed or amended. Other areas of risk referenced the levels of staffing required as a control measure to mitigate against the potential risk and as already stated these could not

be consistently provided. This was reflected under Regulation 15.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. There was evidence of regular fire evacuation drills taking place including drills to reflect minimum levels of staffing. The previous inspection identified that night time drills or minimum staffing drills did not demonstrate that all persons would be safely evacuated in the event of a fire. This had been addressed.

In the first house, the inspectors found residents coats were hung on a valve located on hot pipes leading from a water tank. The temperature of these pipes presented a risk of ignition to the fabric and this was dealt with and reviewed by the person in charge on the day. In the second house, the fire containment measures required review. One resident accessed a bathroom off their bedroom which also opened to the hallway. Despite the resident's bedroom door being closed there were no systems to ensure the bathroom door was also closed. In addition the resident kept their door locked and this could not be opened externally by the staff team thus they had to evacuate via another room rather than directly into the hall. Review was required where pipe work had been extended through the floor and the ceiling and these holes had not been sealed. Also, the attic hatch required review to ensure it met fire containment standards. The insepctors observed one fire door on the utility room had a screw protruding where the provider had fixed a block of wood to accommodate a magnetic door holding mechanism. The integrity of this door required review.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider and person in charge endeavoured to ensure that residents were supported to maintain the best possible mental health and to positively manage their behaviours. Positive behaviour support guidelines were in place, as required. Residents were supported to access psychology, psychiatry and health and social care professionals as required.

The inspectors found that for one resident there had been substantial intervention by health and social care professionals in particular psychology and psychiatry support since the previous inspection. This level of support has had a positive impact for the individual with an associated positive impact on other residents

arising from the management of behaviour that challenges.

In the other house however, the provider had identified that there were concerns in relation to the behaviours of a resident that impacted on the other three residents who lived with them. The need for staff supervision was stated in professional recommendations from consultant psychiatry and in psychology reports as well as in positive behaviour support plans. This was not possible with current staffing levels. In order for staff to try and implement positive behaviour strategies, they had to try and separate residents to maintain distance within their home. Equally as a result of effective staffing arrangements not being in place, staff could not exercise professional responsibility for the services they were delivering. This resulted in these behaviour plans not be fully implemented.

Judgment: Not compliant

Regulation 8: Protection

While the provider had a safeguarding policy and procedures in place, the cumulative findings did not assure the inspectors that some residents in this centre were safe at all times.

The provider had identified a number of safeguarding concerns whereby supervision arrangements were required when residents were together at home and when one resident was in the community. Safeguarding plans in relation to peer to peer incompatibility were developed as required however, the inspectors found that the staffing levels in place did not support the implementation of safeguarding measures as identified in the plans at all times. The absence of systems in place to ensure a resident's safety when they were left unsupervised did not assure the inspectors that the safety of care was prioritised for all individuals in this centre

Judgment: Not compliant

Regulation 9: Residents' rights

The previous inspection found that improvement was required in the first house to ensure residents' had the freedom to exercise choice and control in his or her daily life. Inspectors found that for the most part this had been addressed and additional staffing supports were in place to ensure residents could engage in activities or outings of their choice.

Notwithstanding the findings in the first house, the inspectors identified poor practices in relation to residents' rights in the second house. The residents' choice and control within their home was limited at times. For example, there was no

vehicle assigned to the second house for residents' use. They had access to the day service vehicle and, as stated earlier at the weekend when staff shifts changed, staff had to bring the day service vehicle to the day service building to collect their personal vehicle. This practice resulted in all four residents having to get up and leave their home at a set time to drive with staff on a round trip that lasted at least 45 minutes and was not of resident choice. This decision was made based on the staffing levels in the centre.

The inspectors were informed that one resident recently held an important birthday party with their family and had invited their three house mates. One resident who wanted to attend could not, as staff could only facilitate it if all residents agreed to attend the event. In addition, the staffing levels in place meant that safeguarding plans and positive behaviour support guidelines could not be effectively implemented at all times. For the other residents in the centre, the choice to engage in their community or participate in an individualised activity in the evening is not possible again due to the implementation of staffing arrangements.

Further consideration was also required in relation to the practices that maximised residents' independence relating to the management of the physical layout of their home, and to decisions regarding how they spend their time. For example when a staff member was required to support a resident with personal care in order to implement a safeguarding plan, at times residents would be required to spend time in separate parts of their home due to the inappropriate staffing levels. Where two residents in particular are of retirement age no discussion with them had occurred regarding their right to possibly not have to attend full time day services.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Dun Aoibhinn Services Cahir OSV-0005066

Inspection ID: MON-0039359

Date of inspection: 22/08/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider commits to address issues identified re staffing levels by: 1. Staffing the residence with additional hours to ensure sufficient regular/familiar staff in place at times of the day when needs are greatest, 7 days/week 2. Ensuring the rostering of SAMS trained staff to residence Continuing to escalate to Senior HSE Disability Team re the needs of individuals supported in the residence and the requirement for funding for adequate staffing to meet their needs, through SLA Meetings & Senior HSE Op's Meetings	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider commits to address issues identified re Governance & Management by: 1. Continuing to identify areas of greatest need through internal audits, risk management. Areas of greatest need that are identified are to be prioritised in order of risk rating and non-compliance. 2. Escalating need for funding for the staffing put in place in the 2nd residential house with HSE at next HSE SLA meeting Scheduling review meetings between Residential Key Workers, PIC, Day Service Key Workers & Team Lead and Nursing Support to outline optimal approach to ensure consistency in approach to residents PCP & Care Plans in line with BOC Best Possible Health Guidelines & PCP Guidelines	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The registered provider commits to address issues identified re Premises by: 1. Discussing with landlord of 1st residence the issues in relation to grounds and perimeter fence with a view to having the required works completed 2. Addressing maintenance issues identified by inspectors at time of visit, in 1st residence. 3. Completing identified maintenance works to 2nd residence	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The registered provider commits to address issues identified re Risk Management by: 1. Undertaking a full Review of Risk assessments in both locations, to ensure that they are up to date, relevant and reflective of controls in place.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider commits to address issues identified re Fire Precautions by: Addressing items identified for immediate attention during Inspection dated 22nd Aug 2023 in 2nd residence.	
Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The registered provider commits to address issues identified re Positive Behavioural Support (PBS) by: 1. Staffing the residence with additional hours to ensure sufficient regular/familiar staff in place at times of the day when needs are greatest, 7 days/week 2. Continued/ongoing MDT input, Psychiatry, Psychology, Social Work and Speech & Language, both scheduled and as needed on a priority/emergency basis	

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The registered provider commits to address issues identified re Protection by: 1. Ensuring full compliance with Safeguarding Plans is in place, by putting in additional staffing hours, monitoring Safeguarding Plans through established BOC Safeguarding system. 2. Ensuring Team Based Approach to Safeguarding Plans through central management of residents Care Plans & PCP's, through joint working between Residential & Day Key Workers, PIC & Team Lead 3. Completing Risk assessments for each resident to establish if support plans are required if a resident is left unsupervised in their own home. 4. Support Plan Reviews to be completed through BOC MDT Review's	

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The registered provider commits to address issues identified re Residents Rights by: 1. Staffing the residence with additional hours to ensure sufficient regular/familiar staff in place at times of the day when needs are greatest, 7 days/week 2. Assigning a vehicle to 2nd Residential house on a full time basis for use by residents for access to community and activities of their choice. 3. Completing full review of individuals PCP's, Care Plans in conjunction with their Circle of Support, Key Worker in both Day & Residential, PIC & Team Lead 4. Providing information on Advocacy in an Easy Read Format to the residents and encouraging and supporting residents to participate actively in BOC Regional Advocacy Programme. 5. Residents to be supported to fully understand BOC "I'm Not Happy" option, where they can, confidentially, raise their concerns re the service they are receiving and the	

type of service they would like to receive.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/01/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the	Not Compliant	Orange	31/01/2024

	effective delivery of care and support in accordance with the statement of purpose.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/11/2023
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	31/10/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/10/2023
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/11/2023
Regulation 08(2)	The registered	Not Compliant	Orange	31/10/2023

	provider shall protect residents from all forms of abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/01/2024