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:	Kill Avenue
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	15 June 2022
Centre ID:	OSV-0006747
Fieldwork ID:	MON-0028098

About the designated centre

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

Kill Avenue is a designated centre operated by St. John of God Community Services CLG. This designated centre provides full-time residential services for up to two adult residents with intellectual disabilities and autism support needs. The centre is located near a town in South County Dublin and provides public transport routes and amenities within a reasonable walking distance from the centre. The centre is a one storey property and comprises of two living room spaces a shared kitchen and dining area and two bedrooms. Residents are also provided with adequate accessible toilet and bathing facilities. A well maintained garden space is situated to the rear of the property. The provider has also made arrangements for parking facilities to the front of the property. The centre is managed by a person in charge who is also responsible for two other designated centres located nearby. The person in charge is supported in their role by a social care leader and senior manager. Residents are supported by a team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 June 2022	10:30hrs to 16:30hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

This was an announced inspection and carried out for the purpose of assessing compliance with the regulations which in turn would inform the registration renewal of the centre. The inspector carried out the inspection while wearing a face covering in line with National public health guidance.

Overall, there was a poor level of compliance found on this inspection. Despite the provider, person in charge and staffs' considerable efforts to provide a good quality person-centred service to residents, ongoing incompatibility issues, between residents, were having negative outcomes for them and were impacting on their quality of life and personal well being.

The centre comprised of a detached bungalow located in South County Dublin which provided full-time residential services for two adults with intellectual disabilities and autism related support needs. To the front of the centre there was car parking space and to the rear of the property a well maintained garden/patio space. Residents were provided with two separate living room spaces in the home, their own private bedroom, a toilet and separate accessible toilet/shower facility and a kitchen/dining room area.

The inspector also observed residents bedroom spaces. Residents had chosen to decorate and personalise them to their own preference and taste. Residents bedrooms were well proportioned and could provide them with suitable storage space. The inspector observed in one bedroom where there was considerable damage to one wall where large holes had been created by a resident that occupied the room.

These holes had been patched up with plasterboard and were to be further reviewed by the provider's maintenance team with a view to looking at ways to strengthen the wall to prevent further damage in the future. On review of residents' support planning and discussions with the person in charge, this damage was caused as a result of behavioural instances where some residents experienced aggression and frustration with their current living arrangement.

As discussed, there were poor findings on this inspection related to an ongoing incompatibility issue between residents living in this centre.

Through discussions with the staff and person in charge and on review of documented feedback forms and support planning, it was evident that a high level of restrictions were being imposed on residents in order to keep them separated as a way of reducing the risk of peer-to-peer incidents. Residents' rights to have self-determination, agency and choice in their daily lives were severely impacted as a result.

For example, in an effort to limit the interactions between residents, residents could

not get up and go into the kitchen in the morning when they wanted to, residents did not have a choice around what time they went to bed at. Other examples included occasions when residents were out of the centre and requested to return home because they were tired but this request could not be facilitated by staff as their peer was in the home and their return to the house could cause a behavioural or safeguarding incident.

While there were notable rights restrictions in place in the centre, staff did demonstrate a good understanding of how practices in the centre were not upholding residents rights and expressed frustration that the transition plan for one resident had not come about yet.

The inspector met with and spoke briefly with each resident during the course of the inspection. One resident nodded in acknowledgement of the inspector and gave a thumbs up gesture when the inspector greeted them. The inspector observed staff supporting the resident in a kind and pleasant manner during the course of the inspection.

The resident did not wish to provide feedback to the inspector at the time of inspection but had been facilitated to record their feedback prior to the inspection at a time and in a manner that suited them and facilitated their individual communication style. With the resident's consent, staff had recorded a brief video of the residents' feedback which was shown to the inspector during the course of the inspection.

Through the use of visual aids and gestures the resident was asked did they like their home or did they want to move to another home. The resident responded using their own communication methods by providing a thumbs up and hand signs to communicate they wanted to move to a different home. They also communicated using hand signs what they would like in their own home.

The inspector also observed how the staff arranged for the resident to go on an activity out of the centre before their peer returned from their day service. Staff were observed to be patient, respectful and pleasant to the other resident also. The resident greeted the inspector and asked the inspector what their name was and then went about preparing a snack and settling for the evening.

In summary, the inspector found that each resident’s well-being and welfare could not be supported or maintained to a good standard in this centre despite the considerable efforts made by the staff, person in charge and provider.

This was due to the ongoing incompatibility of residents living in the centre. A transition plan for one resident had not come to fruition due to circumstances outside of the resident and provider's control which in turn meant residents were experiencing a negative lived experience for a prolonged period of time.

Risk management interventions, to reduce the frequency and severity of peer-to-peer safeguarding incidents, while somewhat successful, were having a negative impact in other areas.

High levels of restrictions in residents' daily lives were required in order to keep them safe, and while effective to some extent, had not completely mitigated the safeguarding risk presenting and were in turn having a negative impact on residents' personal well being and impeded residents rights to make even simple choices and decisions in their everyday lives.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

The governance and management systems within the centre, while effective to some extent in their effort to protect residents, were not fully promoting residents rights to freedom and choice in their daily lives and ensuring the service provided was safe and appropriate to meet the needs of residents at all times.

A high number of peer-to-peer safeguarding incidents had occurred in this centre in 2021 and in response to this HIQA requested assurances from the provider on how they were responding to these matters and what their plans were to address them in a manner that met the needs of residents. In response, the provider submitted written assurances, and subsequently carried out, a comprehensive plan to address the safeguarding concerns.

The plan included training staff in the areas of breakaway techniques and positive behaviour support. A review and enhancement of staffing resources to mitigate and manage safeguarding incidents also formed part of the plan. Residents received comprehensive assessment, intervention and review by a wide range of allied professionals to ensure support plans and interventions were evidence based and closely aligned to residents' assessed needs. The provider also made modifications within the home to support some residents to access spaces with enhanced sound proofing to support their need for a quiet space to self-regulate.

Through this process the provider identified one resident's will and preference was to transition out of the centre which would also meet their assessed needs better. In response to this, the provider made arrangements for identifying a suitable alternative home for the resident which would meet their assessed needs and also support their choice of where to live and with whom.

These actions, taken by the provider, had been reasonably effective in reducing the frequency and severity of safeguarding incidents between residents.

However, at the time of inspection the transition plan for one resident had not yet happened and despite a reduction in the frequency of peer-to-peer incidents, some

had occurred in the previous months. In addition, some residents' personal well-being continued to be negatively impacted and was resulting in incidents of self-injurious behaviour, incidents of aggression causing damage to the resident's personal bedroom space and mental health deterioration.

There was a statement of purpose in place that clearly described the model of care and support delivered to residents in the centre. It contained all the information set out in Schedule 1 of the regulations.

There was a suitably qualified and experienced person in charge that met the requirements of Regulation 14 in relation to management experience and qualifications. They were responsible for this centre and two other designated centres located within a short distance from each other. The provider had enhanced the governance and management arrangements in order to support the person in charge in their role and ensure effective supervisory oversight by appointing a social care leader for this designated centre. Their role was to supervise and manage staff on a day-to-day basis in the centre and report to the person in charge.

It was demonstrated the person in charge of the centre had a good presence in this designated centre and was very knowledgeable of the assessed needs of residents and had led and oversaw a number of risk management reviews and initiatives in the centre with a focus on reducing safeguarding incidents and efforts to promote residents opportunities to engage in meaningful activities and ongoing assessment and intervention by an allied professional team.

There were arrangements in place to monitor the quality of care and support in the centre. The person in charge and social care leader carried out various review audits in the centre on key areas related to the quality and safety of care provided to residents. For example, medication management, residents' finances, personal planning reviews, staff training, environmental and infection control audits and reviews of COVID-19 arrangements and contingency planning.

The provider had ensured that an unannounced visit to the centre was completed as per the Regulations. Where areas for improvement were identified within these audits, plans were put in place to drive improvement. At the time of inspection, the provider was in the process of compiling an annual review of the service for 2021. As part of this process the provider was seeking feedback from residents, families and other relevant representatives which would form part of the overall annual report.

Staffing arrangements at the centre broadly reflected what was outlined in the statement of purpose. From a review of the roster, it was evident that there was an appropriate skill-mix of staff employed at the centre. The person in charge had ensured that there was both a planned and actual roster maintained. It was also evident that there were considerable efforts to ensure a high staffing to resident ratio was maintained in the centre at all times.

However, at the time of inspection there were two whole-time-equivalent staffing vacancies which the provider and person in charge were actively trying to recruit for. One vacancy would be filled within a month of the inspection following the

recruitment of a successful candidate.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted a full and complete application to renew registration of this designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the centre that met the matters of Regulation 14.

They were responsible for three designated centres.

The provider had put supervision and governance arrangements in place to support the person in charge in their regulatory management role by appointing a supervisor to operationally day-to-day manage the designated centre.

A social care leader worked in this centre in the role of supervisor and reported to the person in charge.

There was evidence that demonstrated the person in charge was very involved in the oversight and management of the centre and had taken a leadership role in a number of risk management, staff resource and allied professional review initiatives in the centre over the previous year in response to the ongoing incompatibility issues arising in the centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing arrangements at the centre broadly reflected what was outlined in the statement of purpose.

From a review of the roster, it was evident that there was an appropriate skill-mix of staff employed at the centre.

The person in charge had ensured that there was both a planned and actual roster

maintained.

It was evident that there were considerable efforts to ensure a high staffing to resident ratio was maintained in the centre at all times.

However, at the time of inspection there were two whole-time-equivalent staffing vacancies which the provider and person in charge were actively trying to recruit for.

One vacancy would be filled within a month of the inspection following the recruitment of a successful candidate.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, fire safety, infection control and manual handling.

Staff were also provided with additional training to meet the assessed needs of residents, for example, training in infection control, positive behaviour support and breakaway techniques.

The person in charge maintained a register of what training was completed and what was due.

Staff had received supervision from their line manager over the year and there were additional scheduled supervision dates scheduled for the remainder of the year.

There was evidence of staff knowledge checks being performed in the area of infection control which demonstrated a good example of how the person in charge and provider were effectively promoting staff capability and knowledge in this area.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems within the centre, while effective to some extent in their effort to protect residents, were not fully promoting residents rights to freedom and choice in their daily lives and ensuring the service provided was safe and appropriate to meet the needs of residents at all times.

While considerable efforts and resources had been put in place by the provider to keep residents safe, there continued to be peer-to-peer safeguarding incidents and high levels of restrictions in the centre which were having a negative impact on

residents' personal well being.

The provider's plan to support one resident to transition from the centre had not come to fruition due to circumstances outside their control.

Subsequent to the inspection, the provider provided information to HIQA that they had received confirmation of sanctioned funding to support the transition of a resident from the centre to a new home.

The provider was required to make suitable arrangements to support all residents living in the centre to live in a safe environment that was appropriate to meet their assessed needs and to ensure effective and well planned transitions occurred where assessed as appropriate.

The provider had ensured that an unannounced visit to the centre was completed as per the Regulations. Where areas for improvement were identified within these audits, plans were put in place to drive improvement.

At the time of inspection, the provider was in the process of compiling an annual review of the service for 2021. As part of this process the provider was seeking feedback from residents, families and other relevant representatives which would form part of the overall annual report.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had ensure the statement of purpose for the centre met the matters of Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

All required notifications had been submitted to the Chief Inspector in line with the matters as set out in Regulation 31.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider's complaints policy was in in date.

The person in charge maintained a copy of all logged formal and informal complaints in the centre.

The inspector reviewed a sample of complaints that had been logged and noted that there was overall good general adherence to the procedural steps of the provider's complaints policy.

At the time of inspection there was one open complaint which related to the ongoing incompatibility of residents and the negative impact this was having on residents living in the centre.

The complainant had lodged the complaint with the person in charge in 2021 however, the complaint had not been addressed to their satisfaction locally in the centre and had been escalated to senior management within the organisation as a result.

While this demonstrated effective implementation of the complaint policy procedural steps, it was not demonstrated how the provider could address the matters of the complaint given the current living arrangements for residents.

It also demonstrated that the complaint had not been resolved in a timely manner and as a result the complainant's concerns had not been suitably addressed and residents were continuing to experience negative outcomes as a result.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The inspector reviewed actions from the previous inspection in relation to two out of date policies.

The provider had reviewed and updated both policies since the previous inspection.

Judgment: Compliant

Quality and safety

Residents living in the centre were not in receipt of a good quality service. Despite the provider, person in charge and staff efforts to promote a safe service, residents were experiencing high levels of restrictions in their daily lives which were having a negative impact on the personal well being. There was an ongoing and recognised

incompatibility issue in the centre.

Safeguarding incidents, although less frequent, could still occur in the centre and there were a number of incidents where residents engaged in self-injurious behaviour or engaged in property destruction, which on review of some residents' assessments and plans, were deemed to be as a result of their ongoing frustration with their living arrangement.

Safeguarding policies and procedures were in place and were followed closely and aligned to National procedures. Each safeguarding incident that had occurred in the centre had been reviewed and reported as required. Safeguarding plans were in place and had been formalised and there was evidence of input and feedback from the National safeguarding team also. All staff had received training in safeguarding vulnerable adults and a designated officer was in place with contact details provided in the centre.

However, as discussed, despite this, there continued to be an ongoing safeguarding risk present in the centre which impacted all residents. In order to keep residents safe, residents daily lives were managed in such a way so that they rarely spent time with each other and their activities were coordinated and managed to ensure this.

This resulted in a highly restrictive environment and daily lived experience for residents which did not demonstrate that the least restrictive measure for the least length of time, but also impacted on the rights of residents to have choice and control over their daily lives. Residents could not access their home at times they wished if their peer was present, residents had no choice over the time they got up in the morning or went to bed. If residents were in the home at the same time, they were kept separate and therefore could not freely access their home as they wished.

While it was clearly evidenced that residents' behaviour support and mental health needs were reviewed frequently and comprehensively, the overall incompatible living arrangement meant that these supports were not entirely effective. A number of assessments and allied professional reviews consistently referenced the impact the living arrangements had on residents and were identified as a predominant factor and trigger to behavioural episodes which could result in peer-to-peer safeguarding incidents or instances of self-injurious behaviour and property damage.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing and isolation of residents if required. The provider and person in charge had ensured that all staff were made aware of public health guidance and any changes in procedure relating to this.

There was a folder with information on COVID-19 infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment was in good supply and hand washing facilities were available in the centre with a good supply of hand soap and alcohol hand gels available also. Staff were observed to wear face coverings in line with public health guidelines,

throughout the course of the inspection.

The provider had also demonstrated learning and improvement organisationally in the wider context of COVID-19 and there were notable enhanced standard infection control precautions and systems in place in the centre. Staff had received comprehensive infection control training in a number of areas with skills and knowledge checks carried out as part of staff supervision and practice assessment in the centre. infection control audits reviewed implementation of standard precautions in the centre and set out where there were areas for improvement.

The inspector did note there were some minor premises improvements required to ensure the most optimum infection control standards in the centre. For example, there was notable dust collected in a toilet air vent and considerable moisture damage on the ceiling of the toilet which had the potential for development of mould.

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19.

There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing and isolation of residents if required.

The provider and person in charge had ensured that all staff were made aware of public health guidance and any changes in procedure relating to this.

The provider had enhanced the infection control audit arrangements within the organisation with the introduction of a revised infection control audit template which encompassed the review of a number of standard precaution areas in the wider context of COVID-19.

The person in charge had established a number of infection control procedures for the designated centre in relation to laundry management, establishing enhanced cleaning regimes and disposal of clinical and domestic waste.

All staff were observed to wear face coverings in line with the latest public health guidelines. Alcohol hand gel was made available at key areas within the centre and a staff symptom check was also carried out each shift.

Staff had received a good range of enhanced infection control training which also reviewed the areas of standard precautions as well as hand hygiene, donning and doffing of PPE and Covid-19. Staff practical knowledge and competency checks in the area of infection control had also been introduced as a way of increasing staff capability and knowledge in this area. This was a positive initiative taken by the provider and person in charge.

There were some areas required review and improvement to ensure the most optimum promotion of infection control standards in the centre:

- There was an observable collection of dust in the vent of a toilet.
- The ceiling of the toilet was considerably water damaged which had the potential to develop mould.
- The location of the washing machine in the kitchen of the centre required review. Incontinence was a feature in this centre which resulted in soiled linen and clothes being laundered in the centre therefore a review of the location of the washing machine in the kitchen area, was required.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Each resident had received a comprehensive behaviour support assessment by an appropriately skilled and qualified allied professional.

There was evidence of regular review of residents' behaviour support needs and behaviour incidents occurring in the centre were monitored and analysed for trends and potential triggers for them occurring.

However, while comprehensive support planning was in place, the plans outlined clearly that the environment and incompatibility of residents was a trigger for behaviour incidents to occur and clear recommendations were in place for a more optimum environment to be provided to residents to reduce the likelihood and risk associated with behaviours that challenge.

A high level of daily restrictions were in place to manage and prevent incidents of behaviours that challenge which in turn could present physical and psychological risks to residents.

These restrictions had been in place for a considerable period of time and were required in order to manage risks, but were not the least restrictive option and not applied for the least amount of time.

Judgment: Not compliant

Regulation 8: Protection

While there was evidence of good adherence and implementation of National safeguarding policies and procedures, residents could not be fully protected from all forms of abuse in this centre.

Despite formal safeguarding plans in place, considerable allied professional review and recommendations in place, residents continued to experienced instances of physical and psychological abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents rights could not be upheld and promoted in their daily lives.

Residents dignity could not be fully promoted in this centre due to their ongoing experience of psychological distress resulting in instances of behaviours that challenge, property damage and engagement in self-injurious behaviour.

Due to the high level of restrictions and coordination of residents daily lives, in order to mitigate safeguarding risks, residents' right to choice and direction in their lives was significantly impacted and could not be promoted.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 27: Protection against infection	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kill Avenue OSV-0006747

Inspection ID: MON-0028098

Date of inspection: 15/06/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: One staff member, who meets the skills required to support the residents, has commenced on 18-07-2022 Recruitment drive in progress for a second staff member who meets the skill mix required for the location. In the meantime 2 agency staff who have worked in Kill Avenue for 10 months will cover shifts to maintain consistency. Should the recruitment drive not render a successful result by 30-09-2022, a staff member will be transferred from another DC to fill the vacancy. This transfer will come to fruition by 30-10-2022 if required.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Lease to be signed by landlord and SJOG by 19-08-2022 Fire doors to be ordered by 19-08-2022 House to be wired for Cable by 02-09-2022 Access to broadband to be organized by 02-09-2022 Suite of fire works required once fire doors arrive (emergency lighting, doors, alarm panel, door closures, FFE). To be completed by 30-09-2022 Flooring in the resident's bedroom to be replaced by vinyl by 02-09-2022 Registration documentation to be submitted by 30-09-2022 Transition for resident will take one week following registration inspection	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Lease to be signed by landlord and SJOG by 19-08-2022	

Fire doors to be ordered by 19-08-2022
House to be wired for Cable by 02-09-2022
Access to broadband to be organized by 02-09-2022
Suite of fire works required once fire doors arrive (emergency lighting, doors, alarm panel, door closures, FFE). To be completed by 30-09-2022
Flooring in the resident's bedroom to be replaced by vinyl by 02-09-2022
Registration documentation to be submitted by 30-09-2022
Transition for resident will take one week following registration inspection
Review of satisfaction re open complaint to take place by 30-10-2022

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Dust in toilet room vent will be cleaned and cleared by 30-07-2022
Leak in toilet room to be located and repaired. Toilet room ceiling to be cleaned, sealed and repainted by 26-08-2022
Outdoor room to be constructed to facilitate a utility space, inclusive of laundry machines by 30-03-2023 (new gas boiler prioritized for replacement in July 2022)

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Lease to be signed by landlord and SJOG by 19-08-2022
Fire doors to be ordered by 19-08-2022
House to be wired for Cable by 02-09-2022
Access to broadband to be organized by 02-09-2022
Suite of fire works required once fire doors arrive (emergency lighting, doors, alarm panel, door closures, FFE). To be completed by 30-09-2022
Flooring in the resident's bedroom to be replaced by vinyl by 02-09-2022
Registration documentation to be submitted by 30-09-2022
Transition for resident will take one week following registration inspection

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Lease to be signed by landlord and SJOG by 19-08-2022
Fire doors to be ordered by 19-08-2022
House to be wired for Cable by 02-09-2022
Access to broadband to be organized by 02-09-2022
Suite of fire works required once fire doors arrive (emergency lighting, doors, alarm panel, door closures, FFE). To be completed by 30-09-2022
Flooring in the resident's bedroom to be replaced by vinyl by 02-09-2022
Registration documentation to be submitted by 30-09-2022
Transition for resident will take one week following registration inspection

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Lease to be signed by landlord and SJOG by 19-08-2022 Fire doors to be ordered by 19-08-2022 House to be wired for Cable by 02-09-2022 Access to broadband to be organized by 02-09-2022 Suite of fire works required once fire doors arrive (emergency lighting, doors, alarm panel, door closures, FFE). To be completed by 30-09-2022 Flooring in the resident's bedroom to be replaced by vinyl by 02-09-2022 Registration documentation to be submitted by 30-09-2022 Transition for resident will take one week following registration inspection Rights restrictions re the resident's living environment to be removed once transition has been completed by 09-10-2022	

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.	Substantially Compliant	Yellow	30/10/2022
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	09/10/2022
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	30/03/2023

	residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	30/10/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	09/10/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is	Not Compliant	Orange	09/10/2022

	made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	09/10/2022
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	09/10/2022
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	09/10/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and	Not Compliant	Orange	09/10/2022

	living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			