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## The Elms, OSV-0004877, 22 July 2020

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

## Issued by the Chief Inspector

Name of designated centre:	The Elms
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	22 July 2020
Centre ID:	OSV-0004877
Fieldwork ID:	MON-0029754

## About the designated centre

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

In this centre a residential service is provided for a maximum of seven residents over the age of 18 years of age. The centre comprises of three premises, two of which are located in a town in Co. Clare and one which is located in a village in Co. Clare. Two residents live in each house and one house has an additional apartment where one resident resides. Each premises provides residents with access to their own bedroom, shared bathrooms, sitting rooms, kitchen and dining areas, utility space and rear and front gardens. The model of care is social and staff are on duty both day and night to support the residents who live in this service. Management and oversight of the day to day operation of the service is undertaken by the person in charge supported by nominated social care leaders.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	5
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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 - 2015 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 22 July 2020	09:45hrs to 16:45hrs	Mary Moore	Lead

## What residents told us and what inspectors observed

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the introduction and onward transmission of COVID-19. The inspector therefore only visited one of the three houses that comprise this centre. There was reduced occupancy in another house as two residents had temporarily returned home so as to reduce the impact on them and their families of restrictions such as visiting restrictions. Conversely other residents had decided to avail of a full-time residential service during the pandemic. The inspector met with two of the five residents that were living in the centre at this time.

It was evident that the two residents met with had a good quality of life. Living in this centre gave them opportunity to continue to live in their community of origin where they had contact with family and good meaningful community integration and participation.

Residents gave the inspector a warm welcome to their home, they were comfortable with face masks being used and told the inspector that they used them themselves. Residents were engaged and confident in their home and eager to share personal information and photographs, discuss their interests and invited the inspector to see their bedrooms. There was delight at the pending soccer premierships victory that evening, both supported the same team and confirmed that they had access to the required network to watch the match. Clearly family, attendance at family events and family attending their personal celebrations such as big birthdays was an important part of life and the location of the house readily supported this. Residents also spoke openly about their sadness at the recent loss of a beloved family member and shared with the inspector photographs that they liked to keep at hand.

Both residents were active and ordinarily enjoyed busy lives with multiple opportunities to access and enjoy local services and amenities, obviously COVID-19 had impacted greatly on this. Residents were in good form, however and staff reported that given that residents were sociable and lived much of their life in the community, they had coped very well with the restrictions imposed. Staff spoken with were very aware of the impact on residents lives and had sought to keep residents safe, healthy, active and well during this time. There was strong awareness of the challenges posed as services, amenities and communities started to open but in way that was very different to what had previously been experienced. Residents told the inspector that they were happy in life and loved their home but they needed two things. Both residents consumed tobacco products, but only outside of the house and they said that they needed an outdoor shelter. Both residents had interests and hobbies such as woodwork that required a suitable space for this work, the associated tools and other such items; this could not be accommodated within the house. Management were aware of these needs and were exploring options. One resident told the inspector that it would be great if their request for an outdoor recreational space suited to their particular needs was

included in this report.

## Capacity and capability

It was evident to the inspector that providing residents with a safe service and a good quality of life was the focus of the provider. There was much good practice such as the strong community integration mentioned above and a culture of supporting positive risk that enabled residents to enjoy a level of independence and autonomy while receiving the support that they needed from staff. However, the findings of this Health Information and Quality Authority (HIQA) inspection in conjunction with the findings of the very recent (June 2020) internal review completed by the provider indicated a service where monitoring and oversight was not sufficiently effective. Monitoring was not effectively identifying and addressing deficits in processes such as in personal planning, falls prevention plans, the review of restrictive interventions, the completion of mandatory and required staff training, and the adequacy of fire safety arrangements. This did not ensure and assure consistency of quality and safety, and created the potential for risk.

The management structure was clear and consisted of designated roles of social care workers (leaders) that supported the person in charge in the day-to-day management and oversight of the service. The person in charge had responsibility for another designated centre, but was satisfied that this local support and the support received from the senior management team was sufficient to allow them to exercise their management role. The social care leader role in the house visited however did not have protected administration time and this needs to be considered by the provider when reviewing its overall governance systems in light of these inspection findings.

As the inspector was only visiting one of the three houses the inspector reviewed the findings of the recent internal provider review of its own systems and processes designed to ensure that residents received a safe, quality service that was appropriate to their needs. The inspector found that this was a reliable source of evidence as the review was thorough, well-triangulated and transparently reported both what was good in the service and what was found to be not of the required and expected standard. The reviewer, as does HIQA in its work, recognised the possible impact and challenges of COVID-19 on findings but concluded that there were findings that could not be attributed to this as these were areas that should be subject to regular review. For example, the internal review found that significant improvement was needed in the standard of one personal plan, falls prevention planning was not adequate where there was a clear pattern of recent falls and the extent of overdue staff training was described as concerning. The internal auditor was also unable to verify the completion of COVID 19 specific training for a significant number of staff. Actions requiring immediate attention were issued in response to the staff training findings. While this review was relatively recent there were ongoing failings identified by this HIQA inspection. Robust

monitoring by the provider of the action plan from this internal review was required to ensure that there was timely and adequate completion of the required actions and improvement in monitoring and oversight that was sustained.

In light of the internal findings this inspector reviewed staff training records. The provider had reviewed in the context of COVID-19 how it facilitated staff training, these details were available in the centre, some programmes were now available for completion on line. On reviewing the training records in this house the inspector saw that almost all staff listed had up to date mandatory training. However, the provider had not ensured that newly recruited staff despite having received supernumerary induction had completed the available on-line training including safeguarding and fire safety training. The providers systems for monitoring and validating training including training that was self-directed by staff were not sufficient as it was still not possible to verify that all staff had completed the four core (as directed by the provider) infection prevention and control modules required to be completed to assure the providers response to COVID 19. Of seven records reviewed there were deficits in three. The inspector was assured by management that they were confident that the training had been completed but it was accepted at verbal feedback of the inspection findings that systems for following up and verifying completion were not adequate.

The person in charge assured the inspector that they were satisfied that current staffing levels and arrangements adequately met the assessed needs and the number of residents in each of the three houses. Staff spoken with were very aware of the need for staffing levels in this house that supported residents, though they lived compatibly together, to have individualised routines separate from each other. Staff confirmed that this was facilitated three days each week. The staff roster identified each staff and the hours that they worked; the roster indicated that the same staff worked regularly in the centre thereby promoting familiarity and consistency for both residents and staff.

#### Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications and experience required for the role. The person in charge was satisfied that they had the support needed from the provider to effectively manage each of their designated centres. The person in charge was seen to be known and accessible to residents and staff.

Judgment: Compliant

#### Regulation 15: Staffing

Staffing levels and arrangements were appropriate to the assessed needs of the

residents. Residents received continuity of care and supports from a team of regular staff.

Judgment: Compliant

### Regulation 16: Training and staff development

The provider did not have adequate systems for monitoring and validating staff attendance at and satisfactory completion of training including training that was self-directed. The provider had not ensured that newly recruited staff despite having received supernumerary induction had completed the available on-line training including safeguarding and fire safety training.

Judgment: Substantially compliant

### Regulation 21: Records

The inspector found that any of the requested records as listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013) were in place. The records were well maintained.

Judgment: Compliant

### Regulation 22: Insurance

There was documentary evidence that the provider was insured against injury to residents and against other risks in the designated centre.

Judgment: Compliant

### Regulation 23: Governance and management

The findings of this Health Information and Quality Authority (HIQA) inspection in conjunction with the findings of the very recent internal review completed by the provider indicated a service where monitoring and oversight was not sufficiently effective. Monitoring was not effectively identifying and addressing deficits in processes such as in personal planning, falls prevention, the review of restrictive

interventions, the completion of mandatory and required staff training, and the adequacy of fire safety arrangements. This did not ensure and assure consistency, created the potential for risk and did not assure the best possible provision of a safe quality service at all times. Robust monitoring by the provider of the action plan from this internal review was required to ensure that there was timely and adequate completion of the required actions and improvement that was sustained.

Judgment: Not compliant

## Quality and safety

The inspector visited one of the three houses that comprise this centre. In this house it was evident that residents received an individualised service and had significant opportunities to live full and meaningful lives closely linked to family and community. Residents had good ability to report what it was they wanted to do, did not want to do and what it was they believed would make life better for them such as their request for an outdoor, sheltered recreational space. Resident independence and autonomy was supported by staff that facilitated safe, positive risk taking. However, as discussed in the first section of this report deficits in systems of monitoring and oversight had the potential to create risk and did not assure consistency in quality and safety of the service provided.

For example, the internal provider review of June 2020 had found that significant improvement was needed to a residents personal plan. The personal plan is the plan that underpins the support provided to each resident based on their assessed needs and wishes including helping residents to pursue their personal goals and objectives in life. The plan reviewed by this inspector was well presented, detailed and individualised to the resident. There was documentary evidence that the plan was informed by a current assessment, the resident was consulted with and participated in their personal plan and the plan was the subject of regular review by staff and annual review by the multi-disciplinary team. However, the inspector also found that the plan for understanding and supporting behaviours and interventions in use to manage reported behaviours were not adequately reviewed as part of the personal planning process.

The origin of the behaviour support, intervention plan was not clear; based on some narrative seen in the plan it was not evident that the plan was specific to the resident and their current context of care. There was a chemical intervention prescribed to manage and modify behaviours of a specific type. The rationale for its use, objective review and justification of continued use, consideration of possible alternatives, resident rights and consent to this intervention and consideration of the restrictive element of its use were not demonstrated. There was an explicit associated statement in the personal plan that in the context of residents rights needed to be reviewed, amended or supported by objective evidence and

assessment of risk.

The failure to ensure that all staff had completed safeguarding training is addressed under governance in the first section of this report. The inspector was advised that induction did include familiarisation with the providers safeguarding policy and procedures. Residents were seen to readily approach the person in charge with their requests; staff maintained a record of their discussions with residents on how to recognise risks and how to keep themselves safe. One resident was active in the advocacy forum and clearly identified the inspector as someone who could be spoken with in relation to progressing their requests. There was ready access to the designated safeguarding officer and where concerns or risk to resident safety had been identified there was a safeguarding plan and protocol that was reviewed as part of the personal planning process.

Both residents in this house generally enjoyed good health and from records seen, the inspector was satisfied that staff monitored resident well-being and ensured that residents had access to the clinicians that they needed such as their General Practitioner (GP), dentist, optician and mental health supports. Staff were seen to follow-up on interventions and changes such as revised prescriptions and seeking the results of blood-tests.

As stated earlier in this report residents in this house lived very ordinary lives where they had the opportunity to enjoy experiences and opportunities similar to their peers including the experience of work. Residents had many interests such as swimming, soccer and golf and were active participants in their local community. Both residents were delighted to have their contribution to the maintenance of the local church recently recognised. Staff spoken with had strong awareness of the impact of COVID-19 restrictions on residents lives, the measures taken to reduce the impact, and the challenges that were faced in building back up such strong community integration. Staff were committed to this process and residents spent a large part of the day out of the house with staff. Staff however also supported the need for an additional space to accommodate the particular recreational activities and interests of these residents. This was based on learning from the experience of COVID-19 restrictions and the desire to ensure that residents could be meaningfully engaged in their home given the ongoing risk and challenges posed by COVID-19.

While there was scope for improvement overall practice in relation to risk identification and its management promoted resident safety, independence and autonomy. Controls implemented in general were reasonable and proportionate to the identified risk. For example, both residents choose to consume tobacco; residents were provided with health advice and controls were implemented to prevent the risk of fire. One resident liked to spend short periods in the house alone and another resident liked to walk independently to the local shop. Controls included education on road safety and discreet shadowing by staff. However, risk assessments could be improved with more focus on the resident and their particular skills and abilities that made the activity safe; some controls as described by staff were not all included in the risk assessments. Better monitoring of controls was needed; for example the monitoring of the completion by staff of mandatory and required training as mentioned in the first section of this report. Based on these

inspection findings all risks and their management were not supported by an explicit assessment of the risk such as the behaviour and the chemical intervention referred to above in paragraph 3.

Notwithstanding the deficit that arose in monitoring and verifying the completion of required training, the provider was prepared and responded to the risk posed to resident and staff health from COVID 19. The inspector saw and staff spoken with described controls that were consistent with national guidance such as enhanced environmental cleaning, reduced footfall in the centre, no crossover of staff between services, monitoring each day of staff and resident well-being, monitoring of visitor well-being, access to and the use of personal protective equipment, the identification of isolation facilities if needed and the reintroduction and management of visits to the centre or to home in line with national guidance. Residents were informed and supported to develop the skills that they needed to protect themselves such as good and regular hand-hygiene and the use of a face mask as appropriate. However, there were cloth hand-towels evident in shared bathrooms and while staff had supplied a disposable alternative the inspector strongly recommended the removal of the cloth towels and the provision of proprietary disposable hand drying products and dispensers.

Overall the provider took action to prevent the risk of fire and ensured that staff and residents were alerted to the risk of fire. The house was fitted with a fire detection and alarm system, emergency lighting and fire fighting equipment. Documentary evidence that these systems were inspected and tested as required was provided to the inspector. There was evidence of doors designed to contain fire and its products, however the doors were not fitted with self-closing devices. There were no reported obstacles to residents evacuating and the provider tested its evacuation procedures by undertaking simulated drills. Both residents based on the records seen participated successfully in these drills. However, it was not possible to verify that all staff had participated in such a drill as only two of the seven staff that regularly worked in this house (as named on the staff rota) were listed as having participated in the last five recorded drills completed between February 2019 and May 2020.

## Regulation 10: Communication

Residents communicated effectively and knew who to speak with so as to progress their needs and wishes, for example the person in charge, the advocacy forum or indeed the opportunity to speak with the inspector. Residents had access to a range of media including mobile phones and personal tablets. Where support was needed to maximise effective communication and prevent ineffective communication this support such as allowing time and avoiding direction of a resident as opposed to requesting of, was included in the personal plan.

Judgment: Compliant

## Regulation 11: Visits

Practice in relation to suspending, reintroducing and safely facilitating visits to the centre or visits home to family was guided by national guidance in this regard. While visits were suspended residents were supported by staff to maintain contact with family perhaps through phonecalls or ensuring physical distancing.

Judgment: Compliant

## Regulation 13: General welfare and development

From speaking with residents and staff it was evident that residents were supported to live meaningful and fulfilling lives based on their individual skills and choices. Residents had good and meaningful opportunities for community inclusion and integration such as participating in community based programmes to enjoying the experience of work. Residents were supported to develop and maintain friendships and relationships.

Judgment: Compliant

## Regulation 17: Premises

The premises was well maintained and its location provided residents with ready opportunity for community integration and for maintaining contact with family. However, in the context of the particular interests and abilities of these residents, the house did not provide sufficient recreational space. Restrictions to community facilities imposed in response to COVID-19 and the consequent change in how some community services now operated had highlighted this lack of space.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

The approach to risk management sought to protect residents from known and potential risk while also supporting safe responsible risk taking. However, risk assessments could be improved with more focus on the resident and their particular skills and abilities that made the activity safe; some controls as described by staff were not all included in the risk assessments. Better monitoring of controls was

needed; for example the monitoring of the completion by staff of mandatory and required training as mentioned in the first section of this report. Based on these inspection findings all risks and their management were not supported by an explicit assessment of the risk such as the behaviour and the chemical intervention referred to above in paragraph 3.

Judgment: Substantially compliant

### Regulation 27: Protection against infection

The provider had implemented effective measures to protect residents and staff from the risk posed by COVID-19. The recent provider audit monitored adherence to the required protective measures and measured any impact on residents and the service that they received.

Judgment: Compliant

### Regulation 28: Fire precautions

There was evidence of doors designed to contain fire and its products, however the doors were not fitted with self-closing devices. It was not possible to verify that all staff had participated in simulated evacuation drills as only two of the seven staff that regularly worked in this house (as named on the staff rota) were listed as having participated in the last five recorded drills.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

The plan reviewed was well presented, detailed and individualised to the resident. There was documentary evidence that the plan was informed by a current assessment, the resident was consulted with and participated in their personal plan and the plan was the subject of regular review by staff and annual review by the multi-disciplinary team.

Judgment: Compliant

### Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. Generally residents enjoyed good health and staff ensured that residents had access to the range of healthcare services that they required.

Judgment: Compliant

### Regulation 7: Positive behavioural support

The plan for understanding and supporting behaviours and the interventions in use to manage reported behaviours were not adequately reviewed as part of the personal planning process. The origin of the plan was not clear; based on some narrative seen in the plan it was not evident that the plan was specific to the resident and their current context of care. There was a chemical intervention prescribed to manage and modify behaviours of a specific type. The rationale for its use, objective review and justification of continued use, consideration of possible alternatives, resident rights and consent to this intervention and consideration of the restrictive element of its use was not demonstrated. There was an explicit associated statement in the personal plan that in the context of residents rights needed to be reviewed, amended or supported by objective evidence and assessment of risk.

Judgment: Not compliant

### Regulation 8: Protection

The provider had policies and procedures designed to protect residents from harm and abuse. A deficit in these processes is addressed under governance. Residents were supported to develop their awareness and the skills needed for self-protection. There was access as needed and input from the designated safeguarding officer.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

# Compliance Plan for The Elms OSV-0004877

Inspection ID: MON-0029754

Date of inspection: 22/07/2020

## 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
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The registered provider shall ensure that (16: a) staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.</p> <p>The PIC has now ensured that the newly recruited staff member has completed all available mandatory online training including Safeguarding and Fire Safety; and is booked on all additional mandatory training in a timely manner. Risk assessments have been completed to take into account any training which has been provided in an alternative manner/ delayed training dates as a result of Covid-19.</p> <p>The PIC will complete a full review of training records within the centre to ensure that all staff have been booked on all required training or registered for online modules where relevant, including refresher training; and that appropriate records are maintained to evidence training completed.</p> <p>30/08/2020 - timescale for completion.</p>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p>	

The registered provider shall ensure that (23:c) 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.

The register provider shall ensure that all actions from the recent internal review are completed as per assigned timelines and that each service within the designated centre, under the support and supervision of the PIC, are using the files and record keeping review system to ensure ongoing review and monitoring of systems within the centre in a timely and well evidenced manner.

The PIC shall ensure that all actions relating to staff training outlined in the recent internal audit are completed, IP's will be reviewed to include SMART goals and appropriate Falls Prevention & Management planning is completed for one individual.

30/09/2020 - timescale for completion.

The registered provider or a person nominated by the registered provider (23: a) shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

The schedule for the unannounced provider lead audits has been discussed at Senior Management Level and timelines have been confirmed. While the initial six monthly audit took place remotely due to Covid-19 restrictions, the plan is to complete the second 6 monthly review on site unless further restrictions are imposed by public health or unless public health advice restricts visitors to RCFs.

31/12/2020 - timescale for completion.

The PIC acknowledges that due to Covid-19 restrictions, it was not possible to be on-site in each of the locations within the designated centre due to strict public health guidance initially during the Covid-19 lock-down. The PIC is now ensuring that they are on-site ensuring appropriate levels of governance and management to ensure safe and effective supports at all times.

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:  
The registered provider shall make provision for the matters set out in Schedule 6.

The PIC will support the residents to assess their need/ outline their wishes for an

outdoor facility such as a shed for both individuals to be able to use for recreational purposes such as carpentry, arts and crafts, and storage.  
 The PIC in conjunction with the senior management team will make provision for the acquisition of such a facility.

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 shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following:

- A Risk Management Policy is in place in the organisation and the PIC and SCWs are knowledgeable of this policy and adhered to it within the service.
- The PIC will review and update current risk assessments in the centre to ensure all control measures have been outlined in each respective risk assessment and they are proportional to the risks identified.
- The PIC will review risk ratings to ensure they are reflective of the actual risk following implementation of controls.
- The PIC will identify where risks currently managed within the centre have not been adequately specified or expanded upon, specific to the skills and abilities of both the residents and the staff team, in the current register and will ensure all monitoring of risk is evident in the assessments.
- The PIC will use the files and record keeping review system in place to ensure ongoing review of risk, which is timely and effectively documented.

30/09/2020 - timescale for completion.

Regulation 28: Fire precautions

Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:  
 The registered provider shall ensure that effective fire safety management systems are in place by ensuring the following actions are completed:

The PIC, in conjunction with the SMT, will ensure that door closers will be installed on all required fire doors in the main living areas of the designated centre locations and risk assessments to be updated with this control measure on completion of fitting door closers.

The PIC will ensure all staff within the designated centre participate in a simulated fire drill and a fire-drill rota will be developed to ensure all staff participation.

The PIC shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire-fighting equipment, fire control techniques and arrangements for the evacuation of residents.

The PIC will ensure that all newly recruited staff members will complete online fire safety training and familiarise themselves with all emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire-fighting equipment, fire control techniques and arrangements for the evacuation of residents; prior to lone-working within the designated centre.

31/10/2020 – timescale for completion.

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 shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.

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.

To ensure that this is actioned appropriately in relation to the use of chemical intervention for one resident, the PIC will:

- Ensure that a psychiatry review will take place to discuss the current medication for one individual – completed on 11/08/2020.
- Arrange for a comprehensive MDT meeting to take place (scheduled for 24/08/2020) with all relevant stakeholders (including Psychiatrist, Principal Clinical Psychologist and Designated Officer) present to discuss the residents' current behavior support needs.

If deemed necessary for the use of the chemical intervention to continue, the PIC in conjunction with the MDT will review and introduce the required support strategy/ plan, associated risk assessment and restriction intervention protocol for the safe and appropriate use of the prescribed chemical (with the following considerations – rationale for use, objective review and justification of continued use, consideration of possible alternatives, residents rights and consent to this intervention and consideration of the restrictive element of its use).

Following this review, the PIC will review the associated documentation with the team to

ensure the residents' rights are respected while balancing the need for appropriate levels of evidence for the use of such an intervention.

30/09/2020 - timescale for completion

## 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	30/08/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2020
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.	Not Compliant	Orange	30/09/2020
Regulation	The registered	Not Compliant	Orange	31/12/2020

23(2)(a)	provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	30/09/2020
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to	Substantially Compliant	Yellow	30/09/2020

	control the risks identified.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	30/09/2020
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	30/09/2020
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	30/09/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures	Not Compliant	Orange	30/09/2020

	including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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