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:	Sunbeam Lodge Community Group Home
Name of provider:	North West Parents and Friends Association for Persons with Intellectual Disability
Address of centre:	Leitrim
Type of inspection:	Unannounced
Date of inspection:	08 February 2023
Centre ID:	OSV-0001932
Fieldwork ID:	MON-0036852

About the designated centre

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

Sunbeam Lodge Community Group Home is a bungalow situated in a busy town close to all community amenities. It provides full-time accommodation to male and female adults with a moderate to profound intellectual disability and a range of high support needs. The house is staffed by nurses and healthcare assistants. A waking night time arrangement is in place. The centre comprises of 3 bedrooms (one of which is en suite), a bathroom, kitchen, utility room, dining room and sitting room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 8 February 2023	13:00hrs to 19:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection carried out to monitor compliance with the regulations and to assess the quality and safety of care provided to the residents living at Sunbeam Lodge. This centre had a risk inspection in April 2021 and a Regulation 27 infection prevention and control inspection in April 2022. In July 2022, an NF30 notification was submitted as the provider had recruited a new chief executive officer (CEO) who also acts as person participating in management (PPIM) for this designated centre. The inspector found concerns in relation to the governance, management and oversight arrangements in place and a deterioration in regulatory compliance, which impacted on the safety and well being of residents.

Sunbeam Lodge is located on the edge of a busy town and next to two other buildings which provide a respite service and a day service. At the time of inspection, the service provided support to three full-time residents with a range of presentations. This included support with behaviours of concern, high- support medical care needs and end-of-life care.

The property comprised a small bungalow with four bedrooms, a small kitchen, a dining room and a sitting room. The provider had planned to use one of the bedrooms as a second sitting room. However, there were concerns in relation to a leakage from the heating system in the house and its impact on one of the bedrooms provided. The resident sleeping there was required to move from this bedroom and into the smaller sitting room next door. The provider secured the services of an environmental consultant who provided assurances on the safety of the property and a plan of repair was in progress. The person in charge told the provider that they were examining other accommodation options for the residents should they be required to move out during the remedial work period.

On the afternoon of inspection, there were two residents at home. The third resident was at their day service which was located on the same site. The inspector met briefly with one resident who was in their bed in their room. The staff on duty told the inspector that their health had declined and that they were supported by the palliative care team. The inspector found that the residents room was softly lit, warm and cosy. The resident appeared comfortable in their bed and they had personal items that they enjoyed nearby. Their interactions with staff members were kind, caring and respectful. Later that afternoon, the inspector had a short conversation with the resident's family members. They told the inspector that they were very happy with the care and support provided in Sunbeam Lodge and that they appreciated the work of the staff.

A second resident returned to their home later in the afternoon. Although this resident had some communication skills, they did not speak with the inspector. They smiled and sat with them in the sitting room while looking at photographs. It was clear that the staff on duty had a good understanding of the resident's communication style and they were observed providing support promptly if

requested to do so. They said that this resident enjoyed attending the day centre and had good contact with their family members.

The third resident was observed in their bedroom. This was sparsely decorated in accordance with their preferences and assessed needs. The resident did not speak with the inspector. They were listening to music that was playing on a television. Later, they were observed vocalising and moving from their bedroom to the kitchen and then back to their bedroom. They would take staff by the hand from time to time. This resident did not have a formal day service. The staff on duty told the inspector that at times, they would pick up their footwear and show these to the staff on duty. This meant that they wished to leave the centre. Staff told the inspector that they enjoyed long drives and that they provided these when asked. However, this was not always possible. Due to compatibility concerns, the resident did not attend the day centre which was located nearby. However, the day centre was vacant every second weekend and the resident was reported to enjoy going there when it was vacant and quiet. The inspector found that the resident had limited access to facilities for occupation and recreation. This will be expanded on later in this report.

The inspector observed the footfall in the centre throughout the day and found that due to the assessed needs and presentation of residents and the number of people in the house, that the space provided was not sufficient. For example, an inspection was taking place, the staff team were present and family members were visiting. In addition, one resident was moving around the house constantly and there were risks associated with behaviours of concern escalating due to the lack of space. In addition, although there was a garden nearby, there was no garden attached to the property. This meant that when at home, the resident could not go outside independently if they wished to do so.

From what the inspector observed during the inspection, it was clear that the residents were provided with a good level of care and support. The staff on duty were very familiar with the residents and able to adapt and provide for changes in residents support needs if required. Interactions with residents were found to be caring and respectful. However, the inspector found significant concerns relating to the property provided and the governance and management systems in place. The next two sections of this report present these findings and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The inspector found that although there was a defined management structure in place and clear lines of authority, the monitoring and oversight systems in place, this did not ensure that a safe service was provided. Overall, there was a deterioration in compliance since previous inspections, with significant concerns

identified in relation to nine regulations which were found to be not compliant. Furthermore, the inspector noted that the person in charge had a range of responsibilities including the designated centre, a respite service and a day service that operated every second weekend. These will be expanded on below.

The provider had prepared a statement of purpose which was recently reviewed and updated. This was reviewed on the day of inspection and some amendments were made on the day. However, the inspector found that the floor plans were not updated to reflect the change of use of the small sitting room to a bedroom. This was not in line with the requirements of the Schedule 1 of the regulations and an application to vary the registration conditions is required.

Staff had access to training, including refresher training, as part of a continuous professional development programme. Staff were provided with a programme of formal supervision which was up to date. The inspector viewed a sample of training modules and found that some refresher modules in relation to fire safety, moving and handling training and positive behaviour support training required completion. Staff spoken were found to have good knowledge and understanding in relation to residents needs and a plan was in place for outstanding training to be updated.

The provider had ensured that the number, qualifications and skill mix of staff provided was appropriate to the number and assessed needs of the residents. Nursing care was provided and this meant that a resident with high support needs could remain at home. The night-time arrangement in place was changed recently and waking support was provided. Furthermore, the staff team were found to be supportive and responsive to residents' needs. For example, the person in charge explained some changes to the roster on the day of inspection. This was due to the fact that one staff member agreed to go home and take a rest day. This meant that they could fill an unanticipated vacancy on the roster that night and consistency of care and support could be provided.

The inspector found that the governance, management and oversight systems in place failed to ensure that the service provided was safe, appropriate to the residents needs and effectively monitored. The most recent annual review of the quality of care and support provided to residents took place in November 2021 and therefore this required updating. The six monthly provider-led audit was last completed in February 2022 and therefore, this was due. A quality improvement plan was in place, however, it was not effective as it did not monitor the progress of actions identified. In addition, some audits were completed, but when reviewed by the inspector, the information provided was not correct and requirement amendment. For example, an audit on the restrictive practice register used in the centre. Furthermore, risks in relation to positive behaviour support, resident safeguarding and compatibility were not effectively monitored and addressed. Notifications in relation to safeguarding and protection were not submitted to the Chief Inspector in accordance with the requirements of the regulations.

In summary, although there was a defined management structure in place and a dedicated staff team, the systems in place to monitor the quality and safety of care provided to the residents were not effective. Significant improvements were required

in order to bring the service back into compliance with the regulations in this regard. The next section of this report will describe the care and support people receive and if it was of good quality and ensured people were safe.

Regulation 15: Staffing

The provider ensured that the number, qualifications and skill mix of staff was appropriate to the statement of purpose and the assessed needs of the resident. Continuity of care and support was provided

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training, including refresher training, as part of a continuous professional development programme. Staff were provided with a programme of formal supervision which was up to date. However;

- Not all staff training modules were up-to-date. For example positive behaviour support, moving and handling training and fire training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance, management and oversight systems in place failed to ensure that the service provided was safe, appropriate to the residents needs and effectively monitored.

- The most recent annual review of the quality of care and support took place in November 2021
- The six monthly provider-led audit was completed in February 2022 and was due review
- Service level audits that were in place were not always effective
- Risks in relation to safeguarding, positive behaviour support and compatibility were not assessed or addressed
- Safeguarding notifications were not submitted to the Chief Inspector.
- The quality improvement planning process was informal and did not monitor the progress of actions identified

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which did not meet with the requirements of Schedule 1 of the regulations;

- the statement did not provide an accurate reflection of the rooms provided in the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider failed to ensure that incidents in relation to allegations of suspected or confirmed abuse of residents in the form of NF06 notifications were reported to the Chief Inspector in line with the requirements of the regulation.

Judgment: Not compliant

Quality and safety

The inspector found that the care and support provided to the three residents living at Sunbeam Lodge was of good quality on the day of inspection and the staff employed were responsive to their needs. For example, the residents were found to have a range of different support needs and therefore the staff team were required to continually adapt the care they provided. However, there were significant concerns in relation to the overall governance, management and safety of the service provided and its impact on the safety and well being of residents which is reflected in the number non-compliant regulations found.

The provider ensured that appropriate healthcare supports were provided for each resident. This included access to a general practitioner (GP) and to the supports of the multi-disciplinary team. In addition, residents had access to consultant-led care if required and a comprehensive plan was in place for one resident in this regard. As previously mentioned, another resident had access to the support of the palliative care team and a holistic plan for end of life care was in place.

The inspector completed a review of residents' files on the day of inspection. An assessment of health, social and personal care was in place along with a 'Listen to

me' workbook. However, the inspector found that as a whole, the resident's file was not up-to-date and guidance provided was ambiguous. For example, the core nursing assessment contained information relating to meetings that took place in 2017. This had not been updated. In addition, the information in the workbook provided for one resident did not reflect their current circumstances. Furthermore, person-centred goals were not available for review and there was no plan of the supports required to maximise the resident's independence.

Some residents in this designated centre required support with behaviours that were challenging and positive behaviour support plans were in place. One sample reviewed provided a summary of behaviours only. This was not in line with the resident's current presentation. It was not dated and was not signed. Therefore it was not possible to ascertain when it had been reviewed. A second resident has a plan completed by the positive behaviour support therapist however, it required a comprehensive review in order to ensure that behaviour support strategies on the residents file were clear, effective and in line with the safeguarding and protection requirements of the service as a whole.

The inspector found that the provider had not ensured that residents were protected from abuse and responsive measures had not been taken to address safeguarding issues in the centre. This related to incident report forms that were completed by staff. There was a failure to recognise and act on occasions when there may be grounds for concerns in relation to their peer's behaviours of concern. In addition, it related to the failure to update safeguarding plans when required. For example, a safeguarding plan was in place and the safeguarding measures included the resident eating their meals in the small sitting room from time to time. As this room was no longer available, this safeguarding measure was no longer applicable. In addition, safeguarding and protection audits were not effective as trends were not identified.

As previously outlined, the inspector found significant concerns in relation to the premises. This included the fact that one of the bedrooms was closed to residents as there was a substantial concern in relation to a leakage from the heating system. This impacted on the space provided in the property which was not sufficient for the range and presentation of the residents living there. This meant that not all residents were free to use all areas of their home at all times if they wished to do so. This was due to the fact that there were safeguarding concerns in relation to a resident who like to move around the centre on a constant basis. In addition, there was no secure outdoor space provided for the residents to use independently if they choose to do so.

As previously outlined above, one resident did not have access to a structured day service. From a discussion with the staff on duty and a review of the residents care notes, it was clear that they liked to go to the day centre at the weekends when it was vacant. However, this facility was available on two weekends per month only. From time to time, they would request to go for a drive on the bus. However, the staff told the inspector that this was not always possible due other pressing requirements in the service. The inspector found that the resident did not have appropriate access to facilities for occupation and recreation and they were not supported to participate in activities in accordance with their interests, capacities

and developmental needs. Furthermore, although in line with their preferences at the time of inspection, they had very limited access to their community and there was no plan in place to expand the residents day to day lived experience.

The provider had some arrangements in place to assess, management and respond to risk. However, they were not always effective. The risk management and emergency policy was in date and under review. This provided guidance on the completion of incident report forms and the requirement for clarity. However, a review of incident forms found that they were not always clear and this was not in line with the policy. In addition, a review of incident occurring did not provide evidence of follow up by the quality, safety and risk management (QSRM) structure in place. There was a critical incident plan provided at the entrance to the property. This required updating a staff member listed had departed the service. In addition, not all risks identified had a risk assessment in place. This included risks in relation to the oven in the kitchen, excessive seeking of food and the throwing of items at mealtimes.

In summary, a good quality of care was found to be provided on the day of inspection. However, there were significant concerns in relation to the overall governance, management and safety of the service provided and this was reflected in the number non-compliant regulations found.

Regulation 13: General welfare and development

The provider failed to ensure that all residents had access to facilities for occupation and recreation.

- Not all residents had opportunities to participate in activities in accordance with their interests, capacities and developmental needs.
- Not all residents had opportunities to develop and maintain links with their communities

Judgment: Not compliant

Regulation 17: Premises

The provider failed to ensure that the premises was suitable for the number and assessed needs of the residents

- Not all residents had the internal and external space that they required to meet with their behavioural needs.
- The space provided was insufficient to cater for any visitors to the centre

- At the time of inspection, the premises was in need of maintenance and repair in relation to the heating system.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider failed to ensure that the systems in place for the assessment, management and review of risk were effective.

- Not all risks identified had a risk assessment in place. This included risks in relation to the oven in the kitchen, excessive seeking of food and the throwing of items at mealtimes.
- Incidents reported did not always clearly state the facts
- Risk assessments did not demonstrate follow up or follow though in line with the provider's policy

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider failed to ensure that the assessments in place were comprehensive, effective and regularly reviewed.

- Arrangements were not in place to meet with the assessed needs of all residents
- The information provided was ambiguous. For example; a core nursing assessment referred to information gathered in 2017.
- Not all residents had goals in place as part of their personal plan
- The designated centre was not suitable for the purposes of meeting with the assessed needs of all residents

Judgment: Not compliant

Regulation 6: Health care

The provider ensured that appropriate healthcare supports were provided for each resident. This included access to a general practitioner (GP) and to the supports of the multi-disciplinary team. Residents were provided with support at times of illness. This included a comprehensive and holistic plan for end of life care.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector was not assured that the systems in place to support residents with behaviours of concern were effective.

- Not all staff had completed refresher training in positive behaviour support
- Positive behaviour support plans were out of date or not fully and effectively reviewed. For example; one plan provided a summary of behaviours. It was not signed and not dated and therefore it was not possible to ascertain if it had been reviewed.
- Evidence of the completion of positive behaviour support strategies in relation to the provision of blankets or the completion of monitoring charts were not in place or available for review

Judgment: Not compliant

Regulation 8: Protection

The provider had not ensured that residents were protected from abuse.

- Safeguarding and protection concerns were not identified as such
- Safeguarding and protection audits were not effective and trends were not identified
- Safeguarding and protection plans were not updated in line with changes in the centre

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Sunbeam Lodge Community Group Home OSV-0001932

Inspection ID: MON-0036852

Date of inspection: 08/02/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training Needs Analysis reviewed and updated • Outstanding Training to be completed by 30th April 2023 • Discussion with trainer in Positive Behavioural Support held 1st March 2023 – training to be carried out in April 2023 • Studio 3 training scheduled for 16th March 2023	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Annual Review scheduled for 7th March 2003 • Six monthly audit will be scheduled in the near future • Audit process under review and Planned training in Quality Assurance in Health and Social Care to be held 29th March 2023 • Compatibility assessments currently being completed – MDT Review on this resident scheduled for 31st March 2023 • Training in Positive Behavioural Support scheduled for April (subject to confirmation of Trainer availability) • Safeguarding Notifications retrospectively submitted • Quality improvement planning process to be formalized after QA Training in March 2023	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose:	

• Revised Statement of Purpose to be submitted by 10th March 2023 • Boiler (poor condition identified 14th February 2023) to be replaced concurrent to other remedial action and to be completed w/c 27th March 2023

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • Retrospectively reported • All adverse incidents will be reported consistent with new Adverse Incident Reporting Standard Operating Procedure (effective 1st March 2023)	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: • All Service User files reviewed and updated • Person centred goals now identified • Behavioural Support Plans developed by staff reviewed and updated • Behavioural Therapist review of second service user carried out 1st March 2023 – awaiting report • Day Plan to be established, informed by report from Behavioural Therapist (to include more community based activities) on a phased basis • MDT meeting re Service User to be convened (last held September 2022) – 31st March 2023	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A landscape gardener to be commissioned to provide a quotation for major modifications to outside garden (significant gradient in garden rendering the area unsafe for use) to make a usable garden area • Internal space restricted due to requirement to resolve oil leak impacting on resident room, identified November 2022 – work to be commenced 27th March 2023 (subject to specialist contractor availability) • Second sitting room for visitors to be restored to use w/c 6th March 2023 • Quotation for replacement of boiler requested-replacement to be made concurrent to remedial work in service user room	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Quality, Risk and Safety Management (QRSM) meeting scheduled for 14th March 2023 and will incorporate new Adverse Incident Reporting Standard Operating Procedure • Adverse Incident Reporting training held on 27th February 2023 and second date to be planned for staff unable to attend. • Critical incident plan now updated	

• Training in record keeping to be provided to all staff – provider currently being sourced • Review of roles to ensure designated responsibilities for aspects of service, including responsibility for auditing of record keeping to ensure compliance • Risk Assessments reviewed and revised

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Date on core assessment corrected (September 2022) • All Service User files reviewed and person-centred goals now identified • Improvement to external space being progressed (A landscape gardener to be commissioned to provide a quotation for major modifications to outside garden (significant gradient in garden rendering the area unsafe for use) to make a usable garden area

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Behaviour Therapist has conducted a review of Service User plan on 1st March 2023 (report awaited) • Training in Positive Behavioural Support scheduled for 30th April 2023 • New monitoring charts relating to ABC and completion of activity to be provided by Behavioural Therapist and will be completed as required – supports will be provided consistent with behavioural support plan eg provision of blankets • Training in record keeping to be provided to all staff – provider currently being sourced • Staff have been directed to update their Safeguarding Adults at Risk of Abuse Training (HSELand) as required • Formal monitoring of Safeguarding and Protection to be a standing item on the agenda of Quality, Risk and Safety Management meeting (14.03.23) • Safeguarding and Protection Plans for Service Users have been updated. • Potential for electronic care plans to be investigated

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • More effective record keeping to be ensured with designated responsibility • Training in record keeping to be provided to all staff – provider currently being sourced • Role of Designated Officer to be expanded and relevant training provided

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	31/03/2023
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/03/2023
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	Substantially Compliant	Yellow	30/04/2023

	development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/04/2023
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	31/03/2023
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	31/03/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least	Not Compliant	Orange	07/03/2023

	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(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.	Not Compliant	Orange	31/03/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	15/03/2023
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or	Not Compliant	Orange	01/03/2023

	confirmed, of abuse of any resident.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	15/03/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/03/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	20/03/2023