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:	Prosper Fingal Residential Service 1
Name of provider:	Prosper Fingal Company Limited by Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	06 October 2022
Centre ID:	OSV-0003398
Fieldwork ID:	MON-0028926

About the designated centre

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

Prosper Fingal Residential Service 1 is a designated centre consisting of three properties in North County Dublin. The centre can accommodate up to 14 residents both male and female with a mild to moderate intellectual disability. Some residents may also have a secondary disability such as a physical disability, sensory disability or a mental health need. The service operates 7 days a week for 52 weeks of the year. The staff team consists of a person in charge, social care workers, nursing staff and care assistants. The service operates on the principles of person-centredness, respect and inclusion. Staff aim is to provide a safe and comfortable home within a community environment which supports and promotes independence and well being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Thursday 6 October 2022	10:45hrs to 19:10hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This report outlines the finding of an announced inspection of this designated centre, which consists of three homes in north County Dublin. The centre can accommodate up to 14 residents in total. Two of the homes are located within close proximity to one another in a small coastal town, while the third is located 10 kilometres away. For the purposes of clarity, the inspector will refer to each home as 'House One', 'House Two', and 'House Three'.

The designated centre was previously inspected in July 2021. During that inspection the inspector visited House Two and Three during the course of the inspection. No residents lived in House Three at the time of the inspection, as the provider had applied to add the house as a residential unit to the centre to allow for an increased footprint and the admission of four additional residents. Following this inspection, the application to grant the change in footprint was granted. As a result, the designated centre increased from two to three houses and the capacity of residents from 10 to 14.

For this inspection, the inspector spent the majority of the inspection in House One due to the length of time since its previous inspection in November 2019 and due to delays in receiving the requested documentation, discussed later in the report. The inspector then briefly met with the residents living in House Two.

On arrival at House One, some residents were already at day services on the day of inspection, while others were getting ready to go to their day services. The inspector had the opportunity to spend time with one resident before they left, as they stayed behind waiting to meet with the inspector. The resident communicated that they were happy living in the centre and with their housemates. The resident also told the inspector that they liked the staff. The resident informed the inspector that they loved to attend their day services and go out for coffee with staff. The resident was very familiar with the inspection process and the day-to-day operations of the house. They could inform the inspector of the fire procedures, their annual review meeting and their person-centred plan. They showed the inspector their bedroom and pointed out items of interest, including their goal planning folder.

A second resident was waiting to attend a health appointment they attended on a weekly basis. The resident showed the inspector a small sitting room where they liked to sit and listen to their radio. They informed the inspector they were happy living in the centre and had no complaints.

A third resident made repeated attempts to speak with the inspector, but the inspector lacked the necessary knowledge of their specific communication requirements. The resident asked the inspector what county they were from and showed the inspector a picture that was of significance to them. However, the inspector was unable to understand the rest of the information that the resident tried to communicate. The inspector requested assistance from staff to better

comprehend the resident, but, despite repeated requests, the resident was not given extended assistance in communicating with the inspector. At one stage, the resident was encouraged to leave the office, and on another, the inspector had to intervene in order to direct support to the resident. Overall the inspector observed that the resident was not supported to communicate in accordance with their needs.

In the second house, residents had just finished their dinner when the inspector arrived, and residents were seen assisting with household activities such as taking out the bins and cleaning. The inspector met with three residents of the five residents living in the house. One resident had gone home for a visit, and another resident was resting in their bedroom. The inspector observed staff engaging positively with residents and encouraging residents to show the inspector their home and talk about events they had recently attended. The interactions between staff and residents were warm and kind, and residents appeared relaxed and content in the company of staff.

In advance of the inspection, residents were invited to complete questionnaires on their views of the service. Ten questionnaires were completed by residents with support from staff. The questionnaires asked for participant feedback on a number of areas, including general satisfaction with the service, bedroom accommodation, food and mealtime experience, arrangements for visitors to the centre, personal rights, activities, staffing supports and complaints. The feedback was very positive and indicated that residents were happy living in the centre and with quality and safety of care that they received. Many questionnaires reported how happy residents were with the staff, with one resident saying staff were "kind", "funny", and "laughing". The questionnaires also listed activities that residents enjoyed such as shopping, going to the theatre, walks, swimming, going to the gym, meeting family, massages, and eating out.

Contact with friends and family was important to the residents in the centre, and this was supported by the staff team. Relatives were welcome in the centre, and staff also supported residents in visiting their family homes. It was evident that the staff team had put a lot of effort into maintaining and further developing residents' relationships during the COVID-19 pandemic.

Residents were engaged in many various activities both inside and outside of the designated centre. These activities included art club, photography, zumba classes, gardening and quiz nights. The inspector also learned from talking to residents that they enjoyed attending their day service and also going on holidays. One resident spoke about a recent trip they had taken to Cork, and another spoke of their excitement of their up-and-coming trip to Disney Land in Paris.

Resident meetings were held regularly. A review of these meeting minutes demonstrated how the staff kept residents informed of any upcoming events, changes or news regarding the centre. These meetings were also used to support residents' understanding of their rights, to plan activities and meals, and to participate in other day-to-day activities.

Overall the inspector found residents' participation in the running of the centre and

community involvement was encouraged. However, as mentioned throughout this report, it was necessary to make improvements in the need assessment and personal planning to ensure the efficient support of all residents' needs.

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

Capacity and capability

Overall, the inspector found that there was a governance and management structure with systems in place which aimed to promote a safe and person-centred service for residents. The provider had ensured actions from the previous inspection had been addressed. Although oversight of the care and support provided in the centre was strong in many areas, improvement was required in others. This included the review of personal plans, auditing systems and ensuring all records prescribed by the regulations were available and maintained in the centre. As a result there was a decrease in the compliance levels as previously seen in earlier inspections of the centre.

The provider had completed an annual review and unannounced visits to review the quality and safety of care provided in the centre. It is required by the regulations that these visits take place at least once every six months. It was noted that improvement was required to the timeliness of such reviews as a gap of nine months had occurred between the last two completed six-month unannounced visits. The inspector, however, found these reviews were comprehensive in nature, and the summary included discussions with staff to determine their knowledge and provide an opportunity for staff to raise areas for improvement. For example, it was found in the most recent six-month visit by the Chief Executive Officer (CEO) that staff required additional training in the application and use of the computer-based care plan programme. This training was completed by staff, but as explained later in the report, many issues still remained with the personal planning process, in particular the electronic format.

The quality and standards team completed a schedule of audits and reviews of the centre to monitor and oversee the centre's adherence to service policies, procedures and regulations. These included audits of personal plans, finances and health and safety. However, the inspector found that while the audits were effective at identifying areas for improvement, the long gaps between audits did not allow for the timely review of follow-up actions. For example, the last audit in the centre of the personal plans occurred in December 2021, which identified a large number of actions to be completed post-audit. The inspector found similar deficits in the personal plan process during the inspection, indicating that the audits had not been successful in ensuring quality improvement.

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 the three houses in the designated centre. They demonstrated good knowledge of all the residents, and the residents could clearly identify with the person in charge and were very relaxed and comfortable in their company. The provider had put in place governance arrangements to support their regulatory management remit, and a centre-based supervisor formed part of the management team for the centre. The inspector found these support arrangements required further review in order to fully support the regulatory and administration needs of the centre in terms of supervision and auditing as discussed under regulation 23: Governance and management.

The centre was operating with a full staff complement, and the skill mix consisted of nurses, social care workers and healthcare assistants. Staff completed training as part of their professional development to enable them to deliver evidence-based care and support to residents. The person in charge provided informal and formal supervision to staff in the centre. Informal supervision took place on a daily basis and formal supervision was scheduled to take place every three months.

The person in charge maintained a record of all notifications which had been submitted to the Chief Inspector; however, not all minor injuries had been notified in 2022 as required. The inspector found that this did not have a negative impact on the care provided as the person in charge had sufficient oversight of the incident reporting and risk systems.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had ensured that a full application to renew the designated centre's registration had been submitted within the required timelines. This information was reviewed by the inspector before the inspection had taken place.

Judgment: Compliant

Regulation 14: Persons in charge

A new person in charge had been appointed since the previous inspection, and they had commenced their role in February 2022. This individual held the necessary skills and qualifications to fulfil the role. The person in charge worked full-time, and they held the role for this designated centre only.

The person in charge had worked in the organisation for a number of years, and as a result they knew residents and members of the staff team well. Residents were observed to be familiar with the person in charge, and they were clearly comfortable

in their presence.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that the number and skill mix of staff working in the centre was appropriate to the residents' needs. Nursing care was provided to residents' as required and in line with the statement of purpose.

There was a consistent staff team appropriate to the assessed needs of the residents. There was an actual and planned rota which reflected individual and group needs were being met.

Agency staff were not used, and the person in charge used a bank of relief staff known to residents to promote consistency in the care provided for all residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision were completed with all staff working in the designated centre. Regular staff team meetings were also held to discuss residents' care needs, learning from reviews and information sharing.

Staff members participated in a wide variety of training to support them in their roles. This included mandatory training in fire safety, managing behaviours of concerns, medicines management and the safeguarding of vulnerable adults. In response to the COVID-19 pandemic, staff members had also completed training in hand hygiene, infection prevention and control and the use of personal protective equipment. This ensured that staff members could support residents safely throughout the pandemic.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had ensured that the designated centre was adequately insured. This information was submitted to the Health Information and Quality Authority (HIQA) as part of the designated centre's application to renew registration.

Judgment: Compliant

Regulation 23: Governance and management

Overall inspection findings indicated that improvement was required in the monitoring and oversight of the service delivered to ensure greater quality outcomes for residents and higher levels of compliance with the regulations.

The registered provider had arrangements for the oversight and monitoring of the quality and safety of service provided in the centre. An annual review, in accordance with the standards, was completed in March 2022 for the previous year. While the annual review was centre specific and clearly reviewed the effectiveness of the quality and care delivered to residents, there was no written evidence of consultation with residents or their representatives as legally required.

The management structure was clearly defined and staff were aware of their responsibilities in relation to the management of the centre. While it was evident the current local monitoring systems in place endeavoured to achieve positive outcomes for residents, to ensure appropriate oversight of the designated centre at all times, a review of the auditing process was required. This was to ensure actions identified were completed and led to improved practices.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

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

Some small revisions in relation to the management whole-time equivalence (WTE) was required. This was addressed shortly after the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Overall, notification of incidents were reported to the Chief Inspector in an appropriate and timely manner however, the inspector found that not all minor injuries had not been included on the necessary quarterly notification.

Judgment: Not compliant

Quality and safety

Inspection findings found positive aspects of care and support were observed with regard to residents' wellbeing and welfare. Residents were active participants in their homes and community and engaged in many activities that were important to them. However, the inspector found that the governance and management arrangements needed to be improved upon in order to provide sufficient oversight of the annual assessment of the needs of residents and personal plans.

The registered provider had made sure that the building's layout and design accommodated the number and needs' of residents' needs. The premises were well-built and in good condition both interior and exterior. The first property visited by the inspector was a spacious, fully accessible bungalow with five resident bedrooms. The second building was a dormer bungalow, also with five bedrooms for residents. Each resident's bedroom was individually styled to reflect their personal preferences. In order to meet the needs of the residents, adequate storage space and an appropriate size for shared living rooms were provided. The person in charge was identifying any outstanding repair or maintenance issues and was then effectively ensuring actions following actions were in place to address these issues.

The provider had installed fire doors throughout both residential properties, and all doors had been fitted with door-closing devices. This ensured the most optimum fire containment measures were in place. Although regular monthly fire drills were recorded, none could show they accurately represented night-time conditions and staffing levels. For instance, the last stimulated night-time drill only had a partial cohort of residents staying in the centre that night. Additionally, since there were two staff members present for the practice, the minimum staffing levels did not accurately represent a single sleepover staff person. As a result, the inspector was not given the assurance that the entire capacity of residents, with the minimum level of staff was tested for safe evacuation in the case of a fire.

The registered provider had acknowledged the need for improvement to the processes in place to ensure residents retained ownership of their personal finances. For some residents, family members were supporting them in managing their finances. At times, this posed difficulties in residents' accessing their bank accounts. Additionally, potential risks could emerge when an organisation lacks oversight over resident expenditures. The person in charge detailed the steps taken to date in supporting residents' decision-making and maximising their capacity to make financial decisions. The majority of residents now maintained access to their financial accounts and bank statements. Further engagement was required to ensure all residents were afforded the same rights. During the inspection, the inspector asked for a copy of the provider's policy on "Residents' personal property, personal finances, and possessions," but it was not available. It is a legal obligation that the registered provider prepare, adopt, and implement written policies and

procedures on the subjects listed in Schedule 5. Post-inspection the inspector received a policy on residents' finances dated February 2022. The provider was required to review this policy to capture the personal possessions and property of residents.

There was evidence of the provider's implementation of both national and local safeguarding vulnerable adults policies and procedures. Staff had received up-to-date training and refresher training in safeguarding vulnerable adults. Overall, it was noted there was a low number of peer-to-peer incidents that occurred in the centre. Residents got on well with each other, and staff supported residents in availing of individual activities to support their behaviour and safeguarding support needs in this regard.

The inspector reviewed the systems in place regarding the prevention and control of healthcare-associated infections, including COVID-19. A self-assessment regarding planning and infection prevention and control assurance had been recently reviewed by the provider. 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 spoken with demonstrated good knowledge of the guidance in place to promote good infection control measures in the house.

The inspector reviewed the documentation in the centre that was there to guide staff on how best to support the residents with their assessed needs. The inspector found that the requirements of the regulations in relation to the personal plan of each resident were not met in full. Regulation 5 states that the personal plan is subject to a multi-disciplinary annual review which ensures the maximum participation of the resident and their representatives. The review should also assess the effectiveness of the current plan, and recommendations arising out of this review shall be recorded. The review shall also include any proposed changes to the personal plan and the rationale for changes. The registered provider had implemented a new electronic information system that contained residents' assessments and personal plans. The inspector chose to review the assessments of three residents as a sample; however, the electronic version made it difficult to ascertain the above had occurred. These are detailed under Regulation 5: Individual assessment and personal plan.

As previously mentioned the inspector reviewed the communication support plan for one resident. However, it was noted that not all aspects of the plan had been implemented. The resident's support plan for communication was not readily accessible and was not observed by the inspector in practice. The plan detailed the resident's specific communication needs, including the tendency to repeat questions until they were happy with the response. The plan also informed the reader that the resident enjoyed talking to new staff and people and preferred to use Lámh (modified sign language signs) and visual aids. While visual aids were available in the staff office, these were not used throughout the inspection, along with limited Lámh signs.

Regulation 10: Communication

The provider had not ensured that residents were assisted and supported at all times to communicate in accordance with their assessed needs.

While a communication plan had been devised with the strategies to improve and support communication with the resident, these were not reflected in practice.

Staff required additional training and support in order to proactively support residents' communication in line with their assessed needs and be effective communication partners.

Judgment: Not compliant

Regulation 12: Personal possessions

The inspector found that the practices relating to the management and oversight of residents' finances in the centre had strengthened in line with the regulations, best practices and up and coming legislative changes. However, the provider was required to further develop their 'Residents' Finance Policy' to captured the processes and procedures in place managing residents' property and personal possessions.

From meeting with residents and viewing bedrooms in the centre, it was evident that residents were supported to have control over all of their personal possessions, with adequate space to store clothes and other personal effects. Residents' rooms were decorated in line with their preferences and had items such as televisions, photographs, medals and a range of other possessions personal to each resident.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The registered provider provided residents with facilities and opportunities to participate in activities in accordance with their interests. Residents were also supported in developing and maintaining personal relationships and community links.

Feedback from residents directly and their completed questionnaires showed the inspector that residents took part in a wide range of activities and residents were happy with the level of activities. These included going to bingo, art classes, cinema,

swimming, going on shopping trips, meeting friends for coffee, gardening, staying in hotels, visiting hairdressers and attending day services.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to the number and needs of the residents and were in line with the centre's statement of purpose. There was a homely atmosphere in the houses and residents displayed personal photographs and personal artwork throughout the house.

The premises visited by the inspector were well maintained internally and externally and was designed and laid out to meet the assessed needs of the residents. Residents all had their own rooms which had been decorated to suit their personal taste and preferences.

Judgment: Compliant

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 the procedure relating to this.

Adequate supplies of PPE were made available to staff and residents spoken with were knowledgeable on infection control public health guidelines and were supported to implement good infection prevention practices.

Judgment: Compliant

Regulation 28: Fire precautions

There was evidence of effective fire safety systems, including the use of strobe lighting on activation of the fire alarm in the bedroom of a resident with a hearing impairment. Fire-resistant doors, emergency lighting and fire-fighting equipment were also provided. As a result of findings from the previous inspection completed

by HIQA, a fire risk assessment had been completed by a competent fire person.

Improvements were required in the stimulated night-time drills to ensure they reflected night-time conditions in the houses.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A multi-disciplinary review of the residents' personal plans, which involves assessing the plan's effectiveness and taking into account changes in circumstances and new developments, had not occurred annually as prescribed by the regulations. Recommendations leading out from these reviews, including any proposed changes to the plan, the reason for these changes and names of those responsible for pursuing objectives in the plan, were not recorded. The inspector identified issues with the system used to document residents needs and plans as below:

- It was unclear when annual reviews occurred as there were discrepancies between the dates of when annual reviews occurred and when they were entered into the system. In addition, the attendees and meeting notes of such annual reviews were not maintained on the online system
- Information was lost on goal tracking as the section from the hard copy version was not available on the electronic version.
- Documentation viewed by the inspector referred to certain support needs in terms of healthcare care needs or behavioural supports, but these sections had not been completed
- Some personal plans had not been reviewed since 2020, and documentation had to be pulled from the archive in order to supply the inspector with the requested documents.

It was clear that staff found the system difficult and time-consuming to use, resulting in inaccurate records being maintained.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to multi-disciplinary input as required, such as speech and language therapy, occupational therapy, and physiotherapy. Residents had their own general practitioners and received nursing care as required.

As a result of the gaps in the assessment of need and follow through to personal plans, it was found that the required healthcare needs were not documented clearly in order to guide staff practice. For example, the inspector viewed documentation of

one resident who had a diagnosis of osteopenia; however, there was no corresponding care plan in place. Another example was found with a resident with a cardiac concern. It was difficult to disseminate through the electronic system the dates of last attended blood tests and Dexa scans. The inspector requested a copy of a blood test, but it could not be provided for review.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had implemented systems to protect residents from abuse. The systems were underpinned by a comprehensive policy and procedures. There was no active safeguarding plans or concerns in the centre. Staff completed safeguarding training in order to prevent, detect and response appropriately to safeguarding matters.

There was a clear process regarding the management of allegations of suspected abuse, which included the appointment of a designated officer in the organisation. There were no open safeguarding issues/concerns in the designated centre at the time of the inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Prosper Fingal Residential Service 1 OSV-0003398

Inspection ID: MON-0028926

Date of inspection: 06/10/2022

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: (a) Review the PIC level of capacity to ensure it is commensurate with the duties of the role. (b) Introduce system to flag agreed scheduled internal audit dates to auditors two weeks in advance to avoid long gaps between audits. (c) Introduce on-line system by which auditors can monitor and follow up on completion of quality improvement actions. (d) Include written evidence of consultation with residents and their representatives in the 2022 and subsequent annual reviews.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: (a) PIC to cross-check resident non-serious injuries, which do not require immediate medical or hospital treatment and dates they occur, with the Company Safety Officer in advance of submitting quarterly notifications.	

Regulation 10: Communication	Not Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: (a) Multi-disciplinary team to review the resident's communication support plan to ensure all necessary supports are captured and recorded correctly and in full. (b) An overview of the resident's interaction style will be provided to new people prior to meeting the resident. (c) Supporting staff will receive guidance from Prosper SLT on how to support the resident's communication in line with the resident's communication support plan. (d) PIC will monitor that support is provided by staff in accordance with the resident's communication support plan.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: (a) A Personal Possessions policy will be developed and implemented.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: (a) Staff have been informed by the PIC that when completing night time emergency evacuation drills they should reflect the full service user complement and staffing levels; additional staff can attend in an observer capacity. (b) Sleeping emergency evacuation drills are planned for November and December and will reflect full resident capacity and staffing levels.	
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: (a) A review of the existing Assessment of Need process will be undertaken, with a view to streamlining the process through the development of one Assessment tool.	

(b) The refined Assessment of Need tool will be implemented.
(c) A refined ISP review process and documentation will be developed in accordance with the requirements of Regulation 05(6)(a), (c) and (d) and Regulation 05(7)(a) and (b)
(d) The refined ISP review process will be implemented leading to the completion / updating of supports as required.
(e) The existing PCP review process will continue to be implemented.
(f) The PIC will monitor ISP and PCP review and updating of supports.
(g) Staff will receive guidance on the plan review function on iplanit.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
(a) A review of each resident's healthcare needs will be undertaken.
(b) All necessary healthcare supports, including appointments attended, will be recorded in the personal plan.

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	16/12/2022
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/01/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/01/2023

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/01/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/12/2022
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/12/2022
Regulation	The person in	Not Compliant	Orange	28/02/2023

05(1)(b)	charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	30/03/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/03/2023
Regulation 05(6)(d)	The person in charge shall	Not Compliant	Orange	30/03/2023

	ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Not Compliant	Orange	30/03/2023
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Not Compliant	Orange	30/03/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/01/2023