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:	No 3 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	13 February 2024
Centre ID:	OSV-0005135
Fieldwork ID:	MON-0037132

About the designated centre

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

No 3 Seaholly is based on a campus on the outskirts of a city. The centre provides full-time residential support for two residents over the age of 18, with intellectual disabilities including those with autism who may have complex support needs and may require support with behaviours that challenge. The centre can support both male and female residents. The designated centre is a semi-detached bungalow which has been divided into two apartment-style living areas with each apartment having one resident bedroom, a bathroom, a living room and a kitchen area amongst other rooms. Residents are supported by the person in charge, a social care leader, social care works and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 13 February 2024	12:00hrs to 20:00hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Both residents living in this centre were met. While neither engaged directly with the inspector, staff on duty supported the two residents in a respectful manner. In the centre where the residents lived it was seen that parts were brightly decorated while new furnishings had installed since a previous inspection.

This designated centre was located on a campus setting and was connected to another designated centre operated by the same provider. On arrival at No.3 Seaholly to commence the inspection, the inspector went to the centre's front door and rang the doorbell but there was no answer. He then went to the connecting centre where a staff member there informed him that the doorbell for No.3 Seaholly was not working so they alerted staff in that centre of the inspector's presence via telephone. It was later indicated to the inspector that a maintenance request had been submitted to fix the doorbell of the centre.

At the time of this inspection, two residents were living in this centre. The centre was laid out so that each resident had their own side of the centre in an apartment setup with each apartment having its own facilities such as a living room and bedroom in addition to other rooms. Both sides of the centre could be accessed through different doors but some of these were kept locked at times. There was also an interconnecting door to the adjoining designated centre but this was kept locked. As part of the setup of the centre it was seen food was kept in one of the apartment area with food brought over to the other apartment for the resident who lived there. This had been recognised as a restriction on this resident and it was indicated that efforts had been made to leave food in their apartment. Clothes belonging to this resident were also kept in the apartment area of the other resident.

It was queried during this inspection if this amounted to a restriction also but it was indicated that the actions of the resident involved indicated that they did not want clothes to be kept in their bedroom. This resident's bedroom was seen, which did have a wardrobe, and was seen to be brightly painted with a mural from the Lion King animated movie present. The resident's living room also had brightly coloured walls depicting more characters from Disney movies. A family tree mural and a schedule board were seen to be present in the hall area in this resident's apartment. The family tree mural had no photos on it while the schedule board did not seem to be in use. It was later indicated that the resident did not want any family photos on the family tree and that they had no interest in the schedule board.

A similar schedule board was also seen present in the other apartment alongside some framed photographs. A couch was present in this area and it was noted that it had a personalised cushion showing some family members of the resident. The resident's bedroom was seen by the inspector and was noted to be bare in appearance. The inspector was informed that the resident would not tolerate many things in their bedroom. As a result of this the resident's clothes were kept in presses in a utility room. It was observed that since a previous inspection in April

2023, a new press had been installed for this resident's clothes to be stored in. A new couch had also been recently bought for the resident's television room.

The old couch that had been replaced was observed to be stored to the rear of the centre and it was indicated that a request had been made in the weeks leading up this inspection for this couch to be removed. The rear of the centre was an enclosed area and had some garden furniture present while one of the residents had their own separate enclosed area to the side of the centre. This enclosed area had garden benches and a swing present while being surrounded by some wooden fences. Such fences were painted but did appear weathered while one of the fences was also loose when seen by the inspector. Food storage in the centre was also viewed by the inspector which was mostly kept in the kitchen-dining room in one of the apartment areas.

One of the resident's required gluten free food and the inspector was shown a separate press in this room where such food was stored specifically for the resident. It was also indicated that the resident had a separate shelf in the fridge-freezer for gluten free food but when this was shown to the inspector it was seen that one open pack of some gluten free food was stored in a different shelf. A staff member present quickly addressed this when highlighted by the inspector. Separate toasters for gluten and gluten free bread were present in the kitchen-dining room with both located side-by-side. It was indicated that the resident who needed gluten free food had not had toast in some time and that their toaster would be moved if used. Both toasters were observed to be plugged in at their current location when seen by the inspector.

Aside from the kitchen-dining room and the other rooms already referenced, the centre also had a room that was used for seclusion purposes for one resident given their particular needs. It was indicated though that the resident could sometimes enter this room on their own. This room was seen by the inspector and was noted to be padded. The door into this room had a viewing panel for staff to monitor the resident while there was also a closed-circuit television (CCTV) camera present on the ceiling of the room. This camera had not been in use at the time of the April 2023 inspection but had been put into use since then. The feed of the CCTV camera could be viewed from the staff office and it was indicated that the feed was always left on but that the CCTV camera was not recording. The use of seclusion will be discussed further elsewhere in the report.

Both of the two residents living in this centre were met during the inspection. When the inspector first arrived at the centre he was informed that one of these resident was in bed. It was indicated that this resident had particular needs and would sometimes refuse to come out of their bedroom so, depending on the circumstances, staff would regularly ask the resident if they wanted to come out. On this inspection it was seen that the resident did leave their bedroom at times and spent time in their television room and in the kitchen-dining room with staff member. The inspector greeted the resident at such times but aside from looking at the inspector, the resident did not engage with him. Efforts were also made to encourage the resident to leave the centre and towards the end of the inspection

they had left with staff in a vehicle provided.

The other resident was not initially present when the inspection commenced but arrived back to the centre in the afternoon. The inspector greeted this resident soon after they had returned but the resident did not interact with the inspector. The resident spent some time in their living room watching television but left the centre shortly after to go for a drive with staff. When they returned the resident went back to their living room. The inspector went to greet the resident again at this time but the resident made a gesture which a staff member present indicated meant the resident wanted the inspector to leave the room. This request was respected. After this the resident was heard at times to be vocalising and near the end of the inspection, the resident left the centre again with staff to go for a drive.

It was indicated to the inspector that two vehicles were provided for the centre with each resident having their own vehicle. Residents also had access to a room in a day services building located on the campus if they wanted to go to. It was highlighted though that, given their particular needs, one of the residents could often refuse to leave the centre. This contributed to both residents being provided with an integrated day services from their home. Staff spoken with also outlined some of the activities that residents participated in away from the campus which included walks on beaches, going to restaurants and going out for coffee. One of the residents was supported to visit their family at home on weekends while it was indicated that the other received visits in the centre from their relatives.

The staff that were met during this inspection demonstrated a good general knowledge of the residents they were supporting while also being observed and overheard to interact with residents in a respectful manner. For example, on one occasion a resident wanted some food and came to a press with a staff member present letting the resident indicate what food they wanted before giving the resident's choice to them. On another occasion while a resident was watching television in another room, a staff member was heard asking the resident if they wanted to be left alone. When the resident indicted that this was what they wanted, the staff member respected this choice. Both residents did appear comfortable in the presence of staff, who made some pancakes for both residents during the inspection, with one resident seen to hug a staff member at one point.

In summary, the two residents had their own apartment areas which were personalised to the particular preferences of each resident. These residents were comfortable with the staff supporting them. Such staff interacted respectfully with residents during this inspection. Both residents were seen to leave the centre during the inspection and it was indicated that provisions were made to support the residents to engage in activities and to meet relatives.

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

Capacity and capability

The overall findings of this inspection indicated that appropriate resources and staffing supports had been provided to support the needs of the residents. There were indications though that aspects of the oversight and monitoring of this centre needed some improvement. Not all restrictive practices in use had been notified.

Registered until May 2025 with no restrictive conditions, this centre had last been inspected by the Chief Inspector of Social Services in April 2023. That inspection focused on infection prevention and control (IPC) practices in centre as part of a specific programme of inspections focused on that area. The April 2023 inspection found that while IPC measures, systems and structures were provided for, some improvement was needed. These included areas such as cleaning, premises related matters and stock control of personal protective equipment (PPE). In response the provider submitted a compliance plan response outlining the measures that they would take to address such issues. This compliance plan response was accepted and on the current inspection, it was noted that most issues raised by the April 2023 inspection had been addressed. This will be discussed further elsewhere in this report.

The April 2023 inspection also highlighted that a provider unannounced visit to the centre had not been completed in a timely manner. Under the regulations such visits must be conducted every six months. Since that inspection three provider unannounced visits had been carried out including one in January 2024 and another December 2023. It was noted though that the provider's unannounced visit in December 2023 was the first such visit to the centre in over seven months. Reports of all three provider unannounced visits were available for the inspector to review on the current inspection in keeping with the requirements of the regulations and it was seen that they did consider matters relevant to the quality and safety of care and support provided for residents. An annual review for the centre for 2023, another regulatory requirement, had not been completed at the time of this inspection but it was indicated that this was being worked on.

However, the overall findings of this inspection did indicate that aspects of the monitoring and oversight of this centre did need some improvement. As will be discussed further elsewhere in this report, varying information was provided relating to restrictive practices which resulted in further assurances being sought in this area following the inspection. It was also identified during this inspection that not all restrictive practices in use in this centre had been notified to the Chief Inspector as required. While the two provider unannounced visits conducted in December 2023 and January 2024 did consider restrictive practices, it was notable that both listed some different restrictive practices as being in use. This was a concern given that a need for greater oversight regarding restrictive practices in the centre had been highlighted previously during a December 2021 inspection. Additionally, the December 2021 inspection also highlighted a need for improved oversight of fire safety precautions but on the current inspection aspects of fire safety were again found to need improvement. Given that monitoring in the context of IPC had been

identified as requiring improvement during the April 2023 inspection, the overall findings of the current inspection indicated that enhanced general monitoring and oversight was needed to ensure that all relevant matters were identified and addressed.

Aside from this though there was indications that the provider had put in place sufficient resources to support the needs of the residents living in this centre. As mentioned earlier, each resident had their own vehicle while discussions with staff members and documents reviewed indicated that high staffing levels were also provided. In keeping with the requirements of the regulations, staffing provided in a centre must be keeping with the needs of the residents and the centre's statement of purpose (SOP). The overall findings of this inspection indicated that the staffing arrangements provided met the needs of the residents. It was noted though that the staffing ratios actually provided appeared much higher than those outlined in the SOP. This was queried by the inspector. In response, it was indicated that the staffing levels outlined in the SOP reflected the minimum safe staffing levels needed and that the higher staffing ratios actually provided did come from the stated staffing full-time equivalent as outlined in the SOP.

Regulation 15: Staffing

Appropriate staffing arrangements were in place to meet the needs of the residents. Staff rosters were also maintained but the actual staff rosters provided to the inspector did not clearly indicated the actual hours that staff were rostered for waking night staff. In the feedback session for this inspection it was indicated that this was recorded in another document and that rostered hours for such night staff were standard across the campus. Staff files were not reviewed during this inspection.

Judgment: Compliant

Regulation 21: Records

Under this regulation any restrictive practice must be recorded. It was highlighted though in information received following this inspection that the use of a physical hold in March 2023 had not been documented at the time.

Judgment: Substantially compliant

Regulation 23: Governance and management

A provider unannounced visit had not been completed for over seven months between May 2023 and December 2023. While there was evidence of good supports to the residents of this centre and the centre was appropriately resourced, the overall findings of this inspection indicated that monitoring and oversight of the centre did need some improvement to ensure that all relevant matters were identified and addressed.

Judgment: Not compliant

Regulation 3: Statement of purpose

An SOP was in place that contained all of the required information and which had also been recently reviewed.

Judgment: Compliant

Regulation 31: Notification of incidents

Under the regulations any restrictive practices in use in a designated centre must be notified to the Chief Inspector on a quarterly basis. Although relevant notifications had been submitted not all restrictive practices in use had been notified at the time of this inspection. These included the use of a CCTV camera, a locked press in the kitchen-dining room, a use of seclusion in December 2023 and the use of a physical hold in March 2023.

Judgment: Not compliant

Quality and safety

While fire safety systems were in operation in the centre, some improvement was required relating to aspects of fire evacuation arrangements. Support plans in place related to promoting positive behaviour requiring updating. Given varying information provided during the inspection, further assurances were sought following the inspection around the use of physical holds.

The designated centre was equipped with fire safety systems including emergency lighting, a fire alarm and fire extinguishers. Such systems were serviced at regular intervals to ensure that they were in proper working order while daily fire safety checks were also being completed from records provided. The fire evacuation procedures were seen to be on display in the centre while records were provided of

regular fire drills being documented at varied times including times to reflect minimum staffing levels. Such drills records indicated that both residents could refuse to evacuate the centre but the inspector did get some varying information from staff around which resident could refuse. Although residents did have personal emergency evacuation plans (PEEPs) in place which outlined the support required to help the residents to evacuate, one staff member indicated that they would not know what to do if one particular resident refused to evacuate.

It was seen though that these PEEPs contained some different information around evacuation supports compared to separate fire evacuation protocols for the centre overall. For example, while the PEEPs outlined supports to help the residents evacuate, they indicated that residents did not need wheelchairs at any point but the overall fire protocols stated that if residents refused to evacuate a wheelchair was to be used. This was queried and it was confirmed that residents did not need wheelchairs to evacuate and in any case there was no wheelchair present in the centre. The fire evacuation protocols also made explicit mention of where certain items were to be left in specific locations to encourage residents to evacuate. On the day of the inspection, such items were not present in their stated location but were present in other locations in the centre. The inspector was informed that these items had been moved as the residents would not tolerate them in their previous locations.

Records provided indicated that most staff had completed fire safety training although not all staff had. Some staff had also not completed specific training in de-escalation and intervention despite this being listed as an existing control measures in relevant assessments for identified risks in the centre. Particular de-escalation and intervention approaches were also referenced in support plans that the residents had in place which were intended to promote positive behaviour. While staff members spoken with demonstrated a good awareness of these plans, it was noted that these were overdue a review. For example, one of the support plans was last marked as being reviewed in July 2021. These support plans outlined various reactive strategies to support residents. Amongst these were practices that, if used, would amount to restrictive practices in the form of physical holds. While it was strongly indicated by management of the centre that such practices were not in use and had not been approved for use, some staff spoken with explicitly indicated their use to bring one resident to the seclusion room in the centre. No record reviewed during the inspection expressly referenced the use of such holds for any incident nor the approval of such holds for use.

However, given the comments made by staff and the content of certain documentation reviewed, further assurances were sought in this area following the inspection. In response, it was subsequently clarified by the provider that the use of a physical hold had been approved for use in August 2023 and that staff required training for this hold. It was indicated though that this hold had not been used since its approval but that a hold for a resident had been used on one occasion in March 2023. While this was indicated as being used for safety reasons, its use had not been documented and it appeared that management of the centre were initially unaware of its use. Aside from this, it was also noted during the inspection that there was a specific protocol in place setting out under what circumstances

seclusion was to be used. This provided for decisions on its use to be made by a senior staff member and it was indicated that such a staff member was always on duty. The protocol also provided for specific monitoring of the resident to be carried out when in the seclusion room which staff spoken with demonstrated a good awareness of. Records provided also generally indicated that this monitoring had been done. However, the record of one use of seclusion in recent months did not reflect this.

The use of seclusion was being reviewed locally with multidisciplinary input. Referrals had also been sent to the provider's internal committees for review of the use of seclusion although such reviews had yet to take. Other such referrals had also been made for other restrictions in place in the centre during 2023 but these too were awaiting review at the time of inspection. Such referrals related to the financial arrangements in place for both residents. It was indicated that residents had their own bank accounts but that money which residents were legally entitled to was collected by their respective relatives with an allowance then provided for residents. The inspector was informed that such arrangements did not adversely impact either resident but that for one of the resident's there had sometimes been some delays in the allowance being provided. Pending the outcome of the review by the provider's rights review committee, the inspector queried if other relevant professionals had been involved in this matter. Following the inspection it was indicated relevant referrals had been made including to an independent advocate which was followed up. A referral to a social worker had also been made in February 2023 but this had not been followed up by the time of the current inspection.

Regulation 11: Visits

Space was available within the centre for residents to meet visitors in private and it was indicated that one resident received visitors to the centre.

Judgment: Compliant

Regulation 12: Personal possessions

While residents had their own bank accounts it was highlighted that money which residents were legally entitled to was collected by their respectively relatives with an allowance then provided for residents. Referrals had been made related to this with a view to supporting residents to have more control over their own finances. However, it was indicated that a referral to a social worker made in February 2023 not been followed up by the time of the current inspection.

Judgment: Substantially compliant

Regulation 17: Premises

On the day of inspection the premises provided was seen to clean, well-furnished and well-maintained.

Judgment: Compliant

Regulation 26: Risk management procedures

The location of a toaster for gluten free bread being right beside a toaster for other bread needed review from a risk perspective.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Most matters raised during the previous inspection IPC focused inspection in April 2023 had been addressed. For example, PPE seen on the day of the current inspection was found to be in date, cleaning schedules were in place which were indicated as being completed consistently and new storage units had been installed. Training records reviewed indicated that most staff had completed training but there was some gaps in areas such as PPE and hand hygiene. Inside the front door of the centre two wall mounted hand gel dispensers were present. One was marked as being out of order while the other appeared empty when tested by the inspector.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Not all staff had completed fire safety training. Varying information was provided from staff around residents who could refuse to evacuate and one staff member indicated that they would not know what to do if one particular resident refused to evacuate. PEEPs contained some different information around evacuation supports compared to separate fire evacuation protocols for the centre overall. Such documents indicated that certain items were to be left in specific locations to encourage residents to evacuate. On the day of the inspection, these items were not present in their stated location but were elsewhere.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans in place which were informed by assessments of needs and had multidisciplinary input. While the contents of personal plans had generally been reviewed within the past 12 months and it was indicated that such personal plans were in the process of being updated, some of the content of personal plans required had not been reviewed in over 12 months. For example, some healthcare plans for one resident had not been reviewed since September 2022.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Support plans were in place for residents to promote positive behaviour but these had not been reviewed in over 12 months and it was indicated the content of these needed updating to reflect the supports that were being provided to residents at the time of inspection. Not all staff had completed training in de-escalation and intervention nor had staff completed training in a particular hold that had been approved for use in August 2023. Records provided indicated that specific monitoring for the use of seclusion had not been followed on one occasion. In information received following the inspection it was acknowledged by the provider that the use of language in certain documentation related to behaviour required review.

Judgment: Not compliant

Regulation 8: Protection

All staff had completed safeguarding training and it was indicated that there were no safeguarding concerns at the time of inspection. Guidance on providing intimate care was outlined in residents' personal plans.

Judgment: Compliant

Regulation 9: Residents' rights

During the April 2023 inspection it was flagged that monthly residents' meetings were not taking place consistently. The provider's response indicated that such meetings would take place monthly and be documented as such. Despite this, on the current inspection only limited records were provided of such meetings and it was indicated that no such meeting had taken place in January 2024. It was acknowledged though that given the particular needs of the residents that they might not always engage in such meetings. A rights assessment for one resident did not reflect some rights restrictions that were in place for the resident at the time of the assessment.
Judgment: Substantially 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 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for No 3 Seaholly OSV-0005135

Inspection ID: MON-0037132

Date of inspection: 13/02/2024

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: -The registered provider will ensure that any occasion on which restrictive procedures, including physical, chemical or environmental restraint, are used in respect of the resident, the reason for its use, the interventions tried to manage the behaviour, the nature of the restrictive procedure and its duration are recorded and reported appropriately in the centre. -The Person in charge has provided supervision with the local team in relation to restrictive practices within the centre and further discussed the documentation required to record the use of restrictive practices. (05/03/24) -The Person in charge has also reviewed the services fuller lives safer lives policy with the staff team on 5th March 2024. -The Person in charge has ensured that a full review has been completed of all documentation in relation to restrictive practices in the centre. Restrictive practices have been identified and are currently being reviewed by the services behaviour standards committee in line with the services policy Fuller Lives Safer Lives. [30/04/2024] -The Person in charge has ensured that a retrospective NF39A has been submitted on the 23rd February 2024 to the inspector in relation the physical hold that took place in March 2023.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider will 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. This will be achieved by the following:

-The Person in charge will attend support and supervision meetings at minimum monthly to ensure that the structures in place are operating effectively regarding recording and reporting of information. (Ongoing)

-The Person in Charge will review all accident incident reporting forms in detail on a weekly basis and will provide incident learning and feedback to the local team at fortnightly support and supervision meetings.(Ongoing)

-The Person in charge will remain in weekly contact (or more if required) with the Area manager and in the absence of the Area manager, the Person in charge will contact the sector manager to support effective feedback and guidance. (Ongoing)

-The registered provider, or a person nominated by the registered provider, will carry out an unannounced visit to the designated centre at least once every six months. This will include a written report on the safety and quality of care and support provided in the centre and any actions required will be completed to ensure standards of care and support. The registered provider will ensure there is a focus on restrictive practices during this visit. (Ongoing)

-The register provider will ensure that an unannounced visit to the designated centre will take place every 6 months. (31/07/2024.)

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge will ensure the completeness of the report to the Chief Inspector at the end of each quarter of each calendar year in relation to incidents occurring in the designated centre: This will include any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used. (30/04/2024)

The Person in charge will ensure that any occasion where physical, environmental or other restraint was used that they are notified to the Authority on a quarterly basis through a NF39A return. These quarterly returns will include, if appropriate, the use of non-recording CCTV, the locked kitchen press, the use of seclusion and the use of a CPI hold technique (if used in the previous quarter)and the storage of a residents personal possessions including clothes in an adjoining area at their request. (30/04/2024)

-The Person in charge will carry out a weekly review of all accident and incident forms to ensure that any restrictive practices are identified and reported as appropriate. (Ongoing)

-The Person in charge has ensured that a retrospective NF39A has been submitted on the 23rd February 2024 to the inspector in relation the physical hold that took place in March 2023.

-The Person in charge has ensured that a retrospective NF39A has been submitted on

the 14th March 2024 to the inspector in relation the seclusion that took place in December 2023.

Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: -The person in charge will ensure that the original referral made to the Services Social Work team will be followed up with. 15/3/2024 -A meeting will be arranged with PIC, sector manager & social work with the families to discuss the importance of the residents having their own access to their money. The next steps will be determined from the outcome of the meeting. 30/06/2024	
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 has ensured that there are systems in place in the designated centre for the assessment, management and ongoing review of risk. (ongoing) -The registered provider and the person in charge have developed a risk assessment in relation to cross contamination of gluten and non- gluten products. This includes a control measure for the safe storage of a toaster being used for gluten free breads. This toaster is now stored in the press with the gluten free food to ensure no risk of cross contamination. (14/2/24)	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: -The registered provider and the Person in charge will ensure the practical assessment in hand hygiene for all staff. This will be carried out for all staff by the 31st March 2024. -The registered provider will ensure that the facilities manager removes the out of order hand gel dispenser. 31/3/2024 -The Person in charge wills ensure that there are weekly checks made of the hand gel dispensers as per weekly cleaning schedule. This will include refilling of the hand gel dispensers when required. (Ongoing)	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: -The registered provider and the Person in charge have ensured that a full review of Personal emergency evacuation plans has taken place and amendments made to fire evacuation procedures to ensure that PEEPs and evacuation procedures share accurate	

information in relation to individual supports required for the persons supported 01/03/2024.

- The Person in charge will ensure that all staff are aware of what to do in the event of a person supported refusing to evacuate the centre. (05/03/24)

-The Person in charge will ensure that staff requiring Fire Safety training are scheduled to complete same. This will be completed by 31st March 2024.

-The Person in charge will ensure as indicated on the fire evacuation procedure that items to support the persons supported to evacuate safely shall now be located in the staff office as the person supported has indicated that they do not want these items stored at the front door. This is now reflected in the fire evacuation procedure (01/03/2024.)

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
-The Person in charge will ensure that a full review of all Personal profiles for residents in this centre will be completed by the 31st March 2024.

-The Person in charge will ensure that as part of this review, the Healthcare management plans will be reviewed with nursing oversight by the 31st March 2024.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
- The Person in charge has ensured that a request has been made to the training department for all staff to receive additional training in de-escalation and intervention training to include a standing hold to encourage movement. 22/2/2024

-The Person in charge will ensure that all staff complete training to support the de-escalation and intervention training to include a standing hold to encourage movement as required. (25/04/2024)

-The Person in charge has ensured that a full review has been completed of all support plans for residents to promote positive behaviour with the local team on 5/3/2024. This will be further reviewed with involved intensive support worker by 30th April 2024.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
-The registered provider and the Person in charge will ensure that monthly residents meetings take place as per schedule and evidence of same is documented and available for inspection. (Ongoing)

-The Person in charge will ensure that these meetings take place in a format that suits the individual persons supported communication needs. (Ongoing)

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 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	30/06/2024
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/04/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	31/07/2024

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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 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.	Substantially Compliant	Yellow	31/07/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	14/02/2024
Regulation 27	The registered provider shall	Substantially Compliant	Yellow	31/03/2024

	ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 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.	Not Compliant	Orange	01/03/2024
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.	Not Compliant	Orange	31/03/2024

Regulation 31(3)(a)	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 occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	30/04/2024
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.	Substantially Compliant	Yellow	31/03/2024
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	30/04/2024

Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	25/04/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/04/2024
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	30/04/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space,	Substantially Compliant	Yellow	30/04/2024

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