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:	Belltree
Name of provider:	Resilience Healthcare Limited
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	19 October 2021
Centre ID:	OSV-0005635
Fieldwork ID:	MON-0031709

About the designated centre

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

This designated centre is located in a mature residential area on the outskirts of the city. The premises is a two-storey detached house where residents have access to a choice of sitting rooms, a kitchen and dining area, utility room and, their own bedroom. Two of these bedrooms have en-suite facilities. There is a pleasant garden and paved area to the rear of the property. A residential service is provided and, residents have access to an external day service or, receive an integrated type service from their home. A maximum of four residents can be accommodated. The designated centre is open seven days a week and, the model of support is social. The house is always staffed and there are two staff on duty at all times. The management and oversight of the service is delegated to the person in charge supported by a team leader.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 19 October 2021	9:45 am to 4:45 pm	Mary Moore	Lead

What residents told us and what inspectors observed

Based on what the inspector observed and, discussed with residents this was a person-centred service where residents enjoyed a good quality of life. However, there were deficits in some of the arrangements that underpinned the safety of the service such as in the identification, management and review of risk, fire safety arrangements and, infection prevention and control processes. These deficits resulted in non-compliance with the regulations and, did not provide assurance as to the effectiveness of the centres' governance arrangements. These deficits did not provide sufficient assurance that risk was adequately and consistently assessed, managed and monitored, so that residents received the safest possible service including in the event of an emergency or crisis such as a fire or, an outbreak of an infectious disease.

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. This consisted of the use of a face mask, regular hand hygiene, physical distancing and, managing the amount of time spent with staff and residents. The inspector was based in the house and had ample opportunity to meet with staff and residents and, to observe resident interaction with the staff and management team.

On arrival at the house the inspector noted that it was located in a pleasant, mature residential area with some local services available. The house was a short drive from a broad range of facilities and, transport was provided. The house was very well maintained. The person in charge confirmed that it had been redecorated prior to the residents coming to live in the centre. The house was spacious, each resident had their own bedroom, two bedrooms had en-suite facilities and, a choice of recreational space was provided. There were ramps externally that promoted accessibility and, a resident confirmed to the inspector that they could use their mobility aid with ease in the house. However, based on the inspector’s observations, the inspector did recommend consideration of an additional banister on the main stairs; this will be discussed again in the context of risk management.

The inspector met and spoke with all three residents living in the house. Two residents had come to live in the centre in early July 2021; the third resident came to live in the centre from another service in August 2021. The inspector saw that residents were confident and relaxed in their home and, with the staff on duty. The residents were at ease with the inspector and responded openly to the presence of the inspector in their home. One resident clearly identified the person in charge as "the boss". There was an easy rapport between residents and staff as they went about the normal routines of the day such as personal care, planning and preparing meals and, leaving the house to engage in community based activities. Residents were given choice, clearly knew that they could within reason make their own decisions and, they had the right to do so. For example, one resident initially said that they wished to stay in the house rather than go shopping. The resident later changed their mind and was delighted on their return to show their purchases to the

inspector.

Discussions between the residents and the inspector confirmed that they had ongoing access to family and friends and, were supported to maintain friendships that were important to them. One resident told the inspector that moving to the centre was a great benefit in this regard as it was always their wish to return to their home county to live and, to be nearer to family. The inspector saw that this transition had been discussed and agreed with the resident and, a plan was put in place to support a successful transition. This included regular visits to the centre prior to the resident's admission. However, while the person in charge said that the resident had a contract for the provision of services, this was not available for the inspector to see.

Resident's discussed their interests and residents confirmed they had the freedom to express what was important to them, for example their religious beliefs.

Staff and residents planned the itinerary for the week. Staff sought to promote the individuality of the service particularly in relation to community activity and engagement; staff were mindful of the amount of time that residents spent together in the house. Residents came and went with staff throughout the day of inspection. Residents were also happy to do things together. For example, there was much excited discussion with the inspector about an upcoming concert. Residents and staff were planning a day outing for the day after this inspection and, two residents enjoyed a session of bowling on the afternoon of the inspection. However, in the days prior to and, after this inspection there had been some minor differences between residents. This will be discussed again in the body of this report.

All of the above was positive and confirmed the person-centred focus of this service, the participation of residents in their plans and routines and, the choice and control that they had. However, there were also risks that need to be managed so that resident safety was promoted and protected. The person in charge maintained a register of risks and their control. The majority of the residual risk ratings were very low, including the risk associated with COVID-19 which had a green risk rating. The inspector was not assured that the residual risk ratings were correct and accurate, as many controls deemed necessary to manage risk were not in place. For example, there were gaps in staff training such as in First Aid and, in infection prevention and control. The fire risk assessment also had a green risk rating but to date, simulated evacuation drills had not established that all three residents could be effectively evacuated in a timely manner. There were further deficits in the centre's fire safety arrangements such as the failure to adequately familiarise all staff working in the centre with the evacuation procedures.

Overall, there was a deficit in the centre of appropriate evidence based policy and procedures and, explicit risk assessments to support infection prevention and control practice. For example, the infection prevention and control policy in the COVID-19 folder was relevant to the acute hospital services and, the policy on facilitating visits was not current. In addition, the plan for responding to any suspected or confirmed COVID-19 did not provide assurance that it could be successfully implemented so as to control the spread of infection. The person in charge confirmed that staff did not

have access in the centre to the correct level of personal protective equipment that would be needed in the event of suspected or confirmed COVID-19.

The person in charge confirmed that there were two vacancies and, there had been a recent successful recruitment campaign. In the interim, there was a team of regular staff but there was also reliance on relief and agency staff. However, the absence of risk assessments and, the low residual risk rating for COVID-19 was not reflective of these arrangements, for example the cross-over of staff between services. In addition, while the person in charge described procedures for ensuring all persons working in the centre had completed all mandatory and required training, there were significant gaps in the records on file that did not evidence the completion of this training.

The next two sections of this 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

As stated in the opening section of this report this was a person-centred service where residents enjoyed a good quality of life. The centre presented as adequately resourced to deliver on its stated objectives. The primary matter arising was the deficits identified in the arrangements that underpinned the safety of the service for residents and staff, that is the deficits in risk management, in fire safety arrangements and, in infection prevention and control procedures. These deficits and, the failure to identify them prior to this HIQA inspection did not provide assurance that there were management systems in place that ensured both the quality and, the safety of the service were consistently and effectively monitored. These inspection findings were of additional concern given the past regulatory history of this centre.

The local management team consisted of the person in charge supported by a team leader. The person in charge was an experienced manager. The team leader confirmed that they had had opportunity to gain management experience and, to complete relevant training such as in the completion of staff supervisions. The person in charge was also person in charge of another designated centre and, was satisfied the support that was in place gave her the capacity to manage both services. The person in charge confirmed that she had access as needed to her line manager. The person in charge said that she was based in the house two days each week. The person in charge was evidently well known to the residents. There was an out-of-hours on-call system and, a further delegated post of responsibility, the post of senior support worker. The provider in early August 2021 completed the first unannounced provider review of the service as required by the regulations. Actions

had issued from this internal review including the need for a COVID-19 contingency plan, the creation of individual risk registers and, the completion of simulated evacuation drills.

It was evident that the action plan from the internal review had been progressed but not, based on these inspection findings, to the required standard. For example, there were deficits in the COVID-19 contingency plan, in the assessment and management of risk and, in the evacuation procedures. The person in charge confirmed and accepted the inspection findings and, knew from their experience that what this inspection found not to be in place, should have been in place. For example, the person in charge confirmed they had attended the recent HIQA webinar on assessing compliance with Regulation 27 (Protection against Infection) and, understood the significance of the deficits identified in this area.

The agreed staffing levels were two staff members on duty at all times including at night time. The current night-time arrangement was a staff member on waking duty and, a staff member on sleepover duty. The inspector saw that residents had good independence but also had the support that they needed from staff. These staffing levels also allowed staff to support different resident routines and choices. There was a core staff team but there were two vacant posts. In the interim there was reliance on relief and agency staff. There was no evidence that this impacted on the consistency of the support that residents received. For example, based on incident records seen, staff followed specific care protocols. The inspector noted that residents were familiar and comfortable with the staff on duty on the day of inspection and, asked and established what staff were on duty on different days.

However, these staffing arrangements were not adequately reflected in other arrangements such as when assessing risk including assessing the risk to effective evacuation procedures or, when monitoring the completion of mandatory and required training. A training matrix had been implemented as required by the internal review. However, the implementation of the matrix had not resulted in oversight that ensured all training requirements were met. The person in charge confirmed that there were procedures for confirming agency staff had completed mandatory and required training. However, the records provided to the inspector in support of these procedures demonstrated much inconsistency and gaps in their completeness. These gaps included absence of evidence of the completion of training in fire safety, responding to behaviour of risk, hand hygiene and, infection prevention and control training. In addition, it was confirmed that a regular staff member had yet to complete hand hygiene and, infection prevention and control training.

Regulation 14: Persons in charge

The provider had appointed a person in charge. The provider ensured that the person in charge had the necessary qualifications, skills and experience and, that the post of person in charge was full-time.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were appropriate to the number and, the assessed needs of the residents. There was reliance on relief and agency staff. There was no evidence that this impacted on the consistency of the support that residents received.

Judgment: Compliant

Regulation 16: Training and staff development

The implementation of procedures and a staff training matrix had not resulted in oversight that ensured all staff training requirements were met. For example, the person in charge confirmed that there were procedures for confirming agency staff had completed mandatory and required training. However, the records provided to the inspector in support of these procedures demonstrated much inconsistency and gaps in their completeness.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was in place and it contained all of the required information such as the residents name and, the date they were admitted to the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

This was a person-centred service where residents enjoyed a good quality of life. However, this inspection identified deficits in arrangements that underpinned the safety of the service for residents and staff. For example, there were deficits in assessing and managing risk, in fire safety arrangements and, in infection prevention and control procedures. These deficits and, the failure to identify them prior to this HIQA inspection, did not provide assurance that there were

management systems in place that ensured both the quality and, safety of the service were consistently and, effectively monitored. This was of additional concern given the past regulatory history of this centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There was evidence that admission to the centre had been discussed and agreed with the resident. However, a signed agreed contract for the provision of services was not available in the designated centre on the day of inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Based on the records seen in the centre there were arrangements for notifying HIQA of certain events such as the use in the centre, of any restrictive practice.

Judgment: Compliant

Quality and safety

The inspector was assured that this was a person-centred service where the individuality and rights of residents were respected and, residents enjoyed a good quality of life. There was evidence of good practice but the deficits identified by this inspection had the potential to compromise the safety of the service, for example in the event of fire or, an outbreak of an infectious disease such as COVID-19.

The individuality of the support provided was evident in the personal plan reviewed by the inspector. The inspector found that the plan reflected the inspector's discussion with the resident, the facilities provided and, the support observed. It was evident from the plan that the resident was spoken with and listened to and, the resident was comfortable speaking with staff. This consultation included consultation and participation in the plan to transition to this centre. The inspector saw that the resident received support to cope with the challenges presented by life such as loss and bereavement. The plan included the resident's personal goals and objectives, the support to be provided to achieve them, the staff member responsible for this and, the timeframe for their achievement. However, the inspector found that all healthcare needs did not have a specific plan of care; this

area of the plan needed to be developed. The inspector also noted that a referral for behaviour support had been submitted in 2020 based on an identified risk for behaviour of concern but, a positive behaviour support plan to support staff to support the resident was not in place. This aspect of the personal plan needed to be progressed on the basis of the referral but also based on recent incidents that had occurred between residents as reported to HIQA.

There was evident staff awareness of a safeguarding risk that presented and, actions were taken to safeguarded residents from harm and abuse. For example, staff described and, records seen demonstrated that staff sought to develop resident understanding of risk and how to stay safe. There was an open risk for safeguarding and, controls were implemented by staff. The restrictive impact of these controls was recognised. However, based on records seen by the inspector these actions were not achieving increased resident awareness or understanding of the safeguarding risk that presented to themselves and others, including their peers. Given the safeguarding risk that presented there was a requirement for review and, consideration of additional controls. This is addressed below in the context of risk management and review.

The person in charge maintained a log of hazards, their assessment and, management; this register was provided to the inspector for review. The initial observation of the inspector was, risks presenting in the centre were identified, for example, the safeguarding risk referred to above. However, the overall residual risk ratings were low and the majority of the risk assessments had a very low residual risk rating of green. The person in charge advised that this was due to the effectiveness of the controls implemented. However, these inspection findings for example in relation to staff training, fire safety and, infection prevention and control established that many controls were not actually in place. Their absence meant that the residual risk rating should have been higher until they were in place and found to be effective in managing the risk identified. For example, the residual risk rating was green for, the risk for COVID-19, fire safety, first aid, the risk for falls and, infection prevention and control. This inspection found deficits in all of these areas that increased the likelihood and impact of these hazards. For example, overall diagnosis, falls history and, two pre-existing medical conditions increased both the likelihood of and, the impact of a fall; this was not reflected in the low residual risk rating. While there was evidence of falls prevention interventions such as the provision of a mobility aid and good footwear, there were outstanding controls such as the recommendations made following an occupational therapy assessment. In addition, based on the observations of the inspector, safe use of the stairs by residents required further assessment and, possible additional controls such as the provision of a second handrail.

There was evidence of good practice. For example, there were restrictive practices in use in response to risks arising such as the safeguarding risk discussed above. Records seen indicated that residents were consulted with about their use or, requested their use such as the use of bedrails. An evidence based risk assessment established the safe use of the bedrails.

There was evidence of infection prevention and control measures. For example,

inspector well-being was established on arrival, staff were seen to monitor resident well-being and, sanitising products and standard PPE were readily available. Residents knew what good cough etiquette was and, were seen to use a face mask in certain situations, such as when travelling in the service vehicle. Staff were observed to appropriately use their face mask. However, there was a deficit of appropriate evidence based infection prevention and control policy, procedures, guidelines and, risk assessments. For example, as discussed above the COVID-19 risk assessment had a residual risk rating of green. This did not reflect the risk posed by increased incidence in the community, the crossover of staff between centres and services or, the gaps identified in the completion of relevant training by all staff. The inspector did not see and, the person in charge confirmed that while there were controls, there was no assessment of the risk associated with specific activities such as visits to and from the centre and, resident participation in community based activities. In the absence of the explicit assessment of risk, the inspector could not be assured as to the adequacy of the controls described, to the specific circumstances of each resident.

The inspector reviewed the providers contingency plan for responding to any suspected or confirmed COVID-19 in the centre. The inspector was not assured that it was sufficient to respond to and, prevent an outbreak. For example, one section of the plan stated that residents effected would have their meals in their own room while another section said that they would come to the kitchen-dining room. The plan did not address the staffing plan such as the delegation of specific staff to support suspected or confirmed residents. The person in charge confirmed that she did not have on site access to the level of PPE that would be needed by staff in the event that a resident or staff member was suspected to have COVID-19. The infection prevention and control policy in the COVID -19 document folder was for use in an acute healthcare setting. The policy on facilitating visits was not current. The HIQA self-assessment tool had been completed in the centre so as to assess the adequacy of the procedures and arrangements in the centre. However, the use of this tool had not led to better and safer procedures as no areas requiring improvement had been identified.

Improvement was needed in the implementation and oversight of centre specific fire safety procedures including evacuation procedures. For example, the inspector noted that the procedures to be followed in the event of fire were not displayed. The evacuation procedure on file did not demonstrate how it was relevant to the size, design and layout of the centre as it described a process of progressive evacuation, the use of compartments and, adjoining compartments. Staff spoken with were not familiar with the concept of using compartments and said that in the event of fire they would immediately evacuate the building. There were records of three simulated drills on file. However, the simulated drills did not demonstrate how they tested and established that all three residents could be evacuated effectively and efficiently. For example, two of these drills recorded a time of 10 minutes from the start to the end of the drill; the most recent drill did record a satisfactory evacuation time. However, none of the three drills completed included all three residents. The resident who had not participated in a drill had higher physical needs, had a device to assist in evacuation from bed if necessary and, was potentially at risk of physical injury from an underlying medical condition if not assisted

appropriately. This device and, the requirement for careful manual handling was not included in the resident's personal emergency evacuation plan (PEEP). Only three staff had participated in these drills and this was not reflective of the staffing arrangements in the centre, that is the reliance on relief and agency staff. It was confirmed to the inspector that such staff were familiarised with the building layout and, the location of fire safety equipment but did not receive specific instruction on the evacuation procedures.

The premises was fitted with a fire detection and alarm system, emergency lighting, fire-fighting equipment and, doors with self-closing devices designed to contain fire and its products. However, while narrative logs indicated that these systems were maintained at the recommended intervals, the actual certificates of their testing and maintenance were not available in the centre. These were sourced by the person in charge prior to the conclusion of the inspection and, a narrative description of the evacuation procedure was also put in place. However, collectively these inspection findings did not demonstrate adequate oversight of the centres' fire safety arrangements.

Regulation 13: General welfare and development

The support provided to each resident reflected their assessed needs and choices. Residents were seen to have good opportunity for occupation and engagement in their home and, in the community. Residents had opportunity to access further education. Based on what the inspector observed and, what residents said, these opportunities were in line with their preferences, their abilities and, to their liking. Residents were supported to have ongoing access to home, family and, to maintain relationships that were important to them.

Judgment: Compliant

Regulation 17: Premises

The location, design and layout of the centre was suited to the number and the accessed needs of the residents. The house was very well maintained, personalised, homely and welcoming.

Judgment: Compliant

Regulation 18: Food and nutrition

The inspector saw that each residents' dietary likes and dislikes were established as

was any assistance that they might need at mealtimes. The inspector noted that residents were offered choice at lunchtime and, planned their main meals. Residents were supported by staff to participate in the preparation and cooking of their meals.

Judgment: Compliant

Regulation 26: Risk management procedures

The hazards presenting in the centre were identified but, the overall residual risk ratings were low; the majority of identified risks had a very low residual risk rating of green. This inspection found deficits that increased the likelihood and impact of these hazards. For example, specified controls were not actually in place and, their absence meant that the residual risk rating should have been higher until they were in place. This did not provide assurance that risks were accurately assessed, adequately monitored and controlled. Based on these inspection findings there was a requirement for additional controls including further safeguarding controls.

Judgment: Not compliant

Regulation 27: Protection against infection

There was a deficit of appropriate evidence based infection prevention and control policy, procedures, guidelines and, risk assessments. The inspector reviewed the providers contingency plan for responding to any suspected or confirmed COVID-19 in the centre and was not assured that it was sufficient to respond to and, prevent an outbreak. The person in charge confirmed that she did not have in the house, the level of PPE that would be needed by staff, should a resident or staff member be suspected or confirmed to have COVID-19.

Judgment: Not compliant

Regulation 28: Fire precautions

Improvement was needed in the implementation and oversight of centre specific fire safety procedures including evacuation procedures. For example, simulated drills completed to date did not demonstrate how they tested and established that all three residents could be evacuated effectively and efficiently as none of the three drills included all three residents. Only three staff had participated in these drills and, this was not reflective of the staffing arrangements in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The personal plan was individualised to the needs, abilities, preferences and wishes of the resident. However, all healthcare needs did not have a specific plan of care; this area of the plan needed to be developed. The inspector also noted that a referral for behaviour support had been submitted in 2020 based on an identified risk for behaviour of concern but, a positive behaviour support plan to support staff to support the resident was not in place.

Judgment: Substantially compliant

Regulation 6: Health care

The assessment of resident needs included the assessment and identification of any healthcare needs. Staff ensured that residents had access to the services and clinicians that they needed for their ongoing health and wellbeing.

Judgment: Compliant

Regulation 8: Protection

Safeguarding vulnerabilities and risks were identified. Staff sought to develop resident awareness and understanding of how to stay safe. There were safeguarding controls in place in response to an identified risk. Based on the findings of this inspection review and, consideration of additional controls was warranted. This is addressed in the context of risk management.

Judgment: Compliant

Regulation 9: Residents' rights

The service delivered was responsive to the specific needs and abilities of each resident. Residents were regularly consulted with, had input into the support provided and, the routines of the house. Residents could express their religious beliefs if these were important to them. The support observed supported and, promoted resident right to independence, privacy and dignity. Where controls were

needed that impacted on this, the restriction on resident choice and privacy was recognised and, justified by the provider.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Belltree OSV-0005635

Inspection ID: MON-0031709

Date of inspection: 19/10/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All Agency staff to receive Mandatory training, Fire Safety, MAPA, IPC, Children First, Safeguarding of Vulnerable Adults. • New staff are trained in Covid 19/IPC training within one week of start date. • All staff to complete First Aid training by 10th December.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • All actions from this report will be uploaded to the organisations Action Tracking Database. The PIC will provide updates on the system as actions are progressed. The PPIM will monitor these actions. • PIC to review all current risks and evaluate risk rating accordingly. Risk assessments will be reviewed monthly by PIC and Team leader. • Fire Safety audits ongoing and reviewed monthly • Infection Prevention and Control information to be reviewed weekly and update necessary information as it becomes available from Clinical Risk Manager. • "Infection Prevention and Control Checklist for Residential Care Facilities in the Context of Covid 19" to be reviewed as appropriate • Weekly audits to be completed without any gaps-Hand Hygiene. Environmental Checklist	

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • PIC will ensure that all new admissions to the centre will have a Contract of Care. • The current new admission to Belltree has a Contract of Care in place.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • PIC to review all current risks and evaluate risk rating accordingly. Risk assessments will be reviewed according to the level of residual risk according to policy by PIC and Team leader • Infection Prevention and Control information to be reviewed weekly and update necessary information as it becomes available. • Continue to review risk assessments following all incidents and amend controls, actions, and risk rating where appropriate.	
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • Current relevant information is in place regarding Public Health Infection Prevention and Control Guidelines on the Prevention and Management of Covid 19 Cases and Outbreaks in Residential Care Facilities, Normalising visiting to and from Long Term Residential Care Facilities for People with Disabilities • PPE packs are in place containing all relevant PPE in the event of a Covid positive case in the service • The Covid Contingency plan has been reviewed and amended with relevant information i.e., isolation plan including eating arrangements, specific staffing plans, assigning staff to residents.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The next 2 fire drills will capture all staff, to be completed by 30th November. • One resident who had not participated in a drill has done so with no issues since this inspection • Monthly Fire Safety audits to continue. • Fire evacuation procedures are in place in the centre at all exits • The evacuation procedure has been reviewed and amended • One resident's PEEP has been updated to reflect the use of an aid to assist in the event of a fire	
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: • An Osteoporosis plan is in place in one residents Health Action plan. • A referral has been made to the Behavior therapist to carry out a Behavioral assessment for one resident. This will be completed by 10th December.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	10/12/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	23/11/2021
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative	Substantially Compliant	Yellow	22/10/2021

	where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/11/2021
Regulation 27	The registered provider shall 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.	Not Compliant	Orange	30/11/2021
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/11/2021
Regulation 28(4)(b)	The registered provider shall	Not Compliant	Orange	30/11/2021

	ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	10/12/2021