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:	Ballyseedy House
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	08 December 2021
Centre ID:	OSV-0007763
Fieldwork ID:	MON-0034405

About the designated centre

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

Ballyseedy House is a large purpose built detached two-storey house located in a rural area, but within a short driving distance to a nearby town. The centre can provide residential/shared care accommodation for a maximum of six residents of both genders, between the ages of 18 and 65. The centre supports residents with Autism spectrum disorders, intellectual disabilities, physical needs and sensory needs. Support to residents is provided by the person in charge, a team leader and support staff. Each resident has their own bedroom and other facilities in the centre include bathrooms, living rooms, dining rooms, kitchens, a laundry and a staff office.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Wednesday 8 December 2021	10:20 am to 8:10 pm	Conor Dennehy	Lead

What residents told us and what inspectors observed

The atmosphere in the designated centre on the day of inspection was found to be calm and relaxed. Staff members engaged appropriately with residents who were seen to move freely throughout the centre. Overall, the house provided for residents was nicely presented with some Christmas decorations also on display.

On arriving at the designated centre, the inspector briefly viewed the interior of a vehicle for the centre and it was seen that two used face masks were hanging over the vehicle's gear stick. Upon entering the centre, the inspector was greeted by a staff member who requested the inspector to check his temperature and sign in to a log sheet. Later on during the inspection, the inspector was again requested to check his temperature in light of the ongoing COVID-19 pandemic.

Upon completing the COVID-19 checks after entering, the inspector did a walk-through of the premises. Some residents were present in the centre at this time and one of these greeted the inspector but otherwise these residents did not engage with the inspector. It was seen that the premises was purpose built and provided each resident with their own bedroom and large communal areas. Such areas were seen to be well furnished and generally well maintained although it was noted that some doorframes and walls were visibly marked. Some Christmas decorations had been put up which included a Christmas tree in an outside courtyard area.

Overall the premises was seen to be presented in a clean manner on the day of inspection with some staff members on duty observed to be carrying out cleaning at various points during the day. It was also noted that signs relating to COVID-19 and social distancing were on display while dispensers of hand gel were present at various locations in the premises. Stocks of personal protective equipment (PPE) such as gowns and face masks were seen to be available in the designated centre if required.

Throughout the inspection, staff members on duty were generally seen to correctly wear face masks when supporting the residents. However, at one point when entering one of the kitchen areas of the centre, the inspector saw one staff member with their face mask lowered below their chin. It was unclear how long the staff member had been incorrectly wearing their face mask for and shortly after they corrected this. However, during the time when the inspector observed their face mask to be lowered the staff member was seen to engage with one resident in close proximity.

The staff members present were seen to engage with residents in a pleasant and respectful manner during the inspection. For example, staff were overheard to warmly greet one resident after they returned from their day services. Some residents attended day services away from the designated centre while others received their day services in the centre. Within the centre it was seen that items such as art supplies and sport equipment were available for residents' use while a

trampoline was also located right outside the centre. At one point a resident was seen to retrieve a peg board which they proceeded to use.

Multiple televisions were present in the centre while some residents also had tablets devices. While the designated centre did have Internet access to support the use of these, a staff member did highlight how at times the Internet connection could be problematic. At one point during the inspection it was observed by the inspector that some difficulties were briefly encountered in this regard as staff sought to support residents to watch something on one of the televisions. However, later on residents were seen to be watching televisions without any such issues.

When reviewing recent records relating to one resident it was noted the resident was frequently indicating as having gone for drives and watching something on the television or a tablet as activities. While it was noted that this resident had particular needs, their positive behaviour support plan indicated that the resident was to have a range of activities available and to try new ones frequently while a daily planner seen for the resident indicated that they were to be offered activities such as puzzles and using a bike. However, from the records reviewed and talking with some staff, it did not appear that the resident was being offered these.

It was also noted that other residents had things like "sit down at table", "bath" and "tea towel" listed as activities but records did detail other activities for these resident such as dancing and massages. Staff spoken with indicated that some residents were doing much better in this centre than in previous placements and that some residents also participated in activities in the community such as horse riding, swimming and going to the cinema. Such activities were also referenced in the notes of residents' meetings that took place in the centre. The inspector was informed that such meetings were to take place weekly but based on meeting notes reviewed, they had only been taking place monthly in recent times.

It was indicated that residents did engage in these meetings and during the inspection all six resident living in the centre were met. Most did not engage with the inspector although one did indicate that they liked living in the centre. A calm and relaxed atmosphere was overheard and observed during the inspection with residents seen to move freely throughout. It was noted that residents were supported to maintain contact with their families. The most recent provider unannounced visit report for the centre included feedback from a family member of one resident who indicated that they were happy with the supports that their relative was provided with in the centre.

While present in the centre, it was also observed that the centre was provided with fire safety systems including a fire alarm, emergency lighting, fire extinguishers, fire blankets and fire doors. It was observed though that some of the fire doors did not close fully while the doorframe of one such door was missing some pieces. These had the potential to negative impact the intended purpose of such fire doors which is to prevent the spread of fire and smoke in the event of fire while also providing for a safe evacuation route. Fire evacuation procedures were on display in the centre although the inspector did observe a floor plan accompanying such

procedures which did not reflect the actual layout of the centre.

In its current layout the centre did have multiple exit doors to evacuate in an emergency if required. It was noted thought that the push bar on one of these doors was missing. It was suggested to the inspector that the door had been damaged the previous day due to adverse weather. A staff member was seen to open and close this door despite the absence of the push bar although it was noted that it did require some effort to do so. A maintenance man was seen to visit the centre during the inspection to review this door but it remained without the push bar as the inspector was leaving the centre.

In summary, residents were seen to be respectfully treated and the premises provided for residents to live in was generally seen to clean, homely and well-furnished. Residents were being supported to maintain contact with their families. It was seen that residents moved freely throughout the centre while a calm and relaxed atmosphere was overheard and observed for most of the inspection.

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

Ongoing efforts were being made to meet the needs of all residents living in this designated centre. However, improvement was required regarding aspects of the staffing and the monitoring systems in place.

This designated centre was first registered by HIQA in January 2020 to provide a service for a maximum of six residents. In September 2020 the centre received its first inspection from HIQA when five residents were present. At that time a good level overall of compliance was found across the regulations reviewed. Since then a sixth resident had moved into the centre meaning that it was now at its full capacity. The purpose of the current inspection was to assess the levels of compliance with the regulations in more recent times. Overall, this inspection found evidence of some good supports being provided to residents. However, it was also noticeable that more regulatory actions where identified on this inspection when compared to the previous inspection.

Under the regulations the provider is required to monitor the services to residents and the provider did have systems in place to provide for this. These included the provider carrying out an annual review of the centre which assessed if the service provided to residents was in keeping with relevant national standards. The provider is also required to carry out its own unannounced visits to the centre every 6 months which are intended to review the quality and safety of care and support provided to residents. Two such visits had been carried out since the September

2020 HIQA inspection with written reports available for both.

It was noted though that the last visit had been carried out in May 2021, meaning that at the time of the current inspection, it had been over 6 months since the provider's last unannounced visit to this centre. In addition, while the provider had other monitoring systems in place such as medicines audits and environmental audits, taking into account the overall inspections findings, improvements were required in such monitoring systems to ensure that issues were identified. For example, as will be discussed in greater detail below, concerns were raised during this inspection regarding fire evacuation procedures. Such concerns were clearly apparent from relevant documentation and speaking to staff but it was not evident that those involved in the management of the centre were aware of these.

While, this was an area for improvement it was seen that the staff members on duty were generally seen to interact appropriately with residents throughout the inspection while the staff members spoken with demonstrated a good knowledge of the residents they were supporting. Planned and actual rosters were maintained in the designated centre, a sample of which were reviewed by the inspector. It was noted from these that while staffing levels were generally maintained as planned, there were some occasions when certain shifts were not filled. In addition, it was indicated to the inspector that there had been some staff turnover in recent months, and while efforts were being made to fill these vacancies and ensure consistent support for residents, it was suggested that such turnover had contributed to issues highlighted on this inspection such as internal staff checks not being carried out consistently.

Regulation 15: Staffing

Planned and actual staff rosters were maintained in the designated centre. There some were staff vacancies although efforts were being made to fill these with regular agency staff. While staffing arrangements were generally provided as intended, there were times when some shifts had not been filled. Staff files were not reviewed on this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

An annual review of the centre was carried out early in 2021. Provider unannounced visits were also carried out but it had been over 6 months since the last one had been conducted. Some improvements were required in the monitoring systems to ensure that issues were identified, known and addressed.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

One restrictive practice in use had not been notified to HIQA on a quarterly basis as required.

Judgment: Not compliant

Quality and safety

Residents were provided with individual personal plans which contained a good level of guidance on supporting their needs. However, concerns were identified regarding aspects of the fire evacuation arrangements.

As required by the regulations, each resident had their own individual person plan which are intended to set out the needs of residents and provide guidance for staff in supporting these needs. The inspector reviewed a sample of residents' personal plans and found that they had been informed by relevant assessments and generally contained a good level of guidance on how assessed needs were to be met. For example, personal plans were seen to include information on how to support residents with intimate personal care. A process was in operation for residents to be involved in the reviews of their person plans through a process of person-centred planning although it was noted that such planning had not been carried out for over 12 months for one resident.

Included within each resident's personal plans was their own personal emergency evacuation plan (PEEP). These outlined the supports residents required if they had to evacuate in the event of a fire in the centre. When reviewing the PEEP of one resident, which was marked as being reviewed in May 2021, it was indicated that the resident might refuse to evacuate the centre but that this had never been an issue since the resident moved into the centre. The person in charge also said that the resident had not refused to evacuate the centre during fire drills. Despite this, the inspector read records of two fire drills from March and April 2021 where it was clearly documented that the resident in question had refused to evacuate the centre.

In addition, these same drill records indicated that in response to such refusals, the resident was locked in a room in the centre while other residents and staff were evacuated. While there were other drills records where this resident was indicated as evacuating without issue, such a procedure was not an effective measure to ensure that the resident was sufficiently protected and evacuated in the event of a fire. Although the resident's PEEP did include some methods that could be used to

encourage the resident to evacuate, the locking of the resident behind a door was not mentioned in their PEEP. Despite this two members of staff spoken with during this inspection indicated that they would follow such a course of action were the resident to refuse to evacuate.

It was also noted that during the April 2021 fire drill, another resident had not evacuated instead staying in their bedroom during the drill. While it was not clear if this resident had refused to evacuate during this drill, their PEEP had not been reviewed since February 2021. From records provided it was noted that drills were being carried out regularly during the first half of 2021 but only one record of a drill during the second half of 2021 from July was provided. One staff member spoken with indicated that they could not recall a fire drill being done since August 2021. When reviewing other fire safety records in the centre, the inspector reviewed records of weekly tests to be carried out of the fire alarm. From these records it was indicated that only one such check had been conducted since 12 August 2021.

Risk related to fire and other matters such as COVID-19 were contained within the centre's risk register while individual residents had risk assessments in place covering various areas such as their behaviour. To support residents to engage in positive behaviour, resident had specific plans outlining the supports they needed in this area which staff members spoken with demonstrated a good general knowledge of. When reviewing the records relating to one resident it was seen that they had a specific behaviour support plan in place dated June 2021 but there was a separate protocol in place outlining a particular response to certain behaviour from the resident who had been living in this centre since 2020. While this protocol made clear reference to the resident's previous home and staff spoken with indicated that this particular response was not used, it was noted that the protocol was marked as being reviewed in October 2021.

Other documents reviewed during this inspection related to matters of a safeguarding nature. Where any incidents of a safeguarding nature did occur it was seen that, generally, these were investigated with a safeguarding plan put in place and the appropriate statutory bodies notified. Records provided also indicated that staff members had undergone relevant safeguarding training. It was found though that one incident of a safeguarding nature had not been subject to a preliminary screening nor notified to one particular body. This was highlighted to the person in charge during the inspection who retrospectively carried out the required actions before the end of the inspection.

Regulation 13: General welfare and development

Residents were supported to maintain contact with their families. Community based were supported. Facilities were available within the centre for activities to take place. Based on records reviewed and discussion with staff, one resident was not being offered varied activities.

Judgment: Substantially compliant

Regulation 17: Premises

While overall the premises provided was seen to be clean, well-maintained and well-furnished, some markings were seen on some walls and door frames.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A risk register was in place along with various risk assessments relating to individual residents. A sample of such risk assessments were reviewed which were noted to have been recently reviewed while staff members spoken with had a good knowledge of risks present in the centre.

Judgment: Compliant

Regulation 27: Protection against infection

Cleaning was seen to be carried out on the day of inspection. Stocks of PPE were seen to be present in the centre and staff were generally seen to wear face masks correctly. However, at one point the inspector did see a staff member wearing their face mask in an incorrect manner and briefly being in close proximity to a resident during this time. Used face masks were seen to be hanging from the gear stick of one of the centre's vehicles. Hand gels were available throughout the centre. A self-assessment on infection prevention and control had been carried out in October 2021.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Based on fire drill records and discussions with staff members on duty, one resident was to be locked inside a room in the centre in the event that they refused to evacuate. Residents' PEEPs were not being reviewed to take account of fire drills. Some of the fire doors and their door frames required review to ensure that they were operating as intended. Some fire evacuation procedures on display were

accompanied by floor plans that did not reflect the actual layout of the designated centre. Gaps were noted in some internal staff checks for weekly tests of the fire alarm.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

This regulation was not reviewed in full during the inspection but it was noted that one resident's assessment for the self administration of medicines was last done in September 2020 when the resident lived in another designated centre while the protocol for a PRN medicine (medicine only taken as the need arises) contained contradictory information about the the maximum number of doses that could be administered in a 24 hour period.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had individual personal plans in place which were informed by relevant assessments and contained a good level of information on how to support residents with their needs. Residents could be involved in the development and review of their personal plans through person-centred planning but it was noted that it had been over 12 months since one resident's person-centred planning had taken place.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents had positive behaviour support plans in place and staff members spoken with generally demonstrated a good knowledge of these. Correspondence received following the inspection indicated that all staff working in this centre had not completed relevant training.

Judgment: Substantially compliant

Regulation 8: Protection

Records provided indicated that all staff member had undergone relevant safeguarding training. Where any safeguarding concerns arose they were generally responded to appropriately but a preliminary screening and subsequent referral to a statutory body had not taken place in a timely manner for one incident. Guidance was available on supporting residents with intimate personal care.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were seen to be treated respectfully during the inspection and residents' meetings were taken place where issues such as activities and food were discussed. It was indicated to the inspector that residents engaged in such meetings and that they took place weekly. However based on records reviewed, such meeting were only taking place monthly in recent times. It was indicated that a matter relating to one resident's health had not been explored with the resident to determine what the resident wanted to do about this.

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ballyseedy House OSV-0007763

Inspection ID: MON-0034405

Date of inspection: 08/12/2021

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: As discussed with the Inspector on the day of the inspection and identified by the Inspector in this report all efforts are being made and continue to be made to fill all shifts on the planned rosters and fill vacant positions. Regular Agency staff have been brought in to ensure safe staffing levels and are identified in the roster. There is one staff recruited to start in January 2022 and one SSW transferring from another house for a period of three months to support the staffing issue. Continued Recruitment is occurring but as the Social Care sector nationally is in crisis regarding staff shortages there continues to be difficulty in recruiting and retaining relevant qualified staff, however there is a local recruitment drive taking place in the Kerry area and an Open Day is planned for February 2022 which will hopefully be successful in recruiting staff for current vacancies. 1:1 staffing is planned and one shift per day is an extra shift planned in the roster to support extra activities.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: As discussed with the Inspector on the day of Inspection regulatory Provider Inspections were taking place on a six monthly basis by one person who finished this role in November 2021. Another service has since been sourced to provide this service for Resilience, these Inspections have commenced with the services and an Unannounced Provider Inspection will occur in Q1 of 2022. There is an incident reporting system in place that alerts to the manager and team lead when any incident is reported, these are reviewed by the manager and any actions are	

then alerted to the staff team. All staff have been made aware to ensure they report any irregular occurrences in particular relating to fire evacuation so that any risk can be identified and actioned. The Manager or Team Lead will review the documentation and complete an action plan. The Team Lead will also on a weekly basis check the documentation completed from the previous week to ensure that any irregular occurrence has been reported.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
One Restrictive Practice was not reported in the last Quarterly Report to HIQA this was a new Restriction that had been added and was an oversight by the Manager. The Manager will ensure to submit this in the next Quarterly due by the end of January 2022. All other HIQA notifications were reported and available for the Inspector on the day of Inspection.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
As discussed with the Inspector on the day of Inspection there have been staff changes in the Centre where three of the longer term residential staff have transferred to the New Direction Programme. This has had an impact on the regular activities for one service user as due to their behaviours of concern it takes time to for the s/u to become familiar with new people and also for staff to become familiar with the s/u. All Agency staff are regular and are becoming familiar with the s/u's files and personality and are working more closely with this service user. All staff are aware of the need to ensure that all service users are offered a selection of activities and their choices responses recorded in their activity records. This will be reviewed by the Manager or Team Lead during s/u audits monthly and any issues highlighted at team meetings.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The marks on the door frames and walls are due to one service users propelling their wheelchair along the corridors. This is something that the s/u likes to do and it promotes their independence. The internal painting is due be completed in the 2nd or 3rd quarter of 2022.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: On the day of Inspection the Inspector observed 2 masks on the gear stick this has been addressed with the staff team and all staff are aware that at all time used masks and other PPE are to be disposed of immediately in the bins provided. One staff member was observed on the day by the Inspector to have their mask around their chin while in close proximity to a service user. All staff are aware of the Public Health Guidelines which have again been discussed at December team meeting and will continue to be addressed at monthly team meetings along with all other IPC procedures.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: On the day of Inspection the Inspector pointed out two fire doors that did not close fully when released and one fire door where the fire frame required replacement. A local provider has been contracted in and will assess all the fire doors and complete any relevant work to ensure compliance. On the day of Inspection the regulatory requirement for fire evacuations was provided to the Inspector but as outlined by the Inspector in the report there were two instances where two service users refused to evacuate. The manager has informed all staff at team meeting and by email that all unusual occurrences relating to fire evacuation are to be reported on the Incident Reporting System which will alert the manager and team lead. This will allow for the risk assessment to be reviewed and an action plan put in place. All PEEPS will be reviewed for 2022 to reflect current plans and on going reviews as required if incident occurs. With regard to one service user refusing to leave during a fire evacuation drill and reference to being locked in their room, this was part of an old PEEP in the s/u's previous home. The current PEEP does not specify this as part of the s/u's fire evacuation plan. The reviewed PEEP will reflect that at no time is the use of locking a service user in their	

room to be considered this will be communicated to the staff team through email, team meeting.

The fire door which was damaged in the storm the night before the inspection has been repaired with bar in place on the 9th of December.

The new Fire Representative for the house has recently completed fire training and is allocated one hour per week to ensure that all fire safety precautions an checks are implemented and will feed back to the team lead or manager with regard to any actions or follow up required.

The team lead will plan to check the fire safety records on a weekly basis to further ensure that all are being completed and follow up on any actions.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The service manager will complete a full audit of all service users medication information and update the current PRN protocols to ensure that they concur with the prescriptions. Medication Management Audits will take place six monthly.

Any out of date information or reference to another service will be archived.

All service users will have their self administration of medication reviewed with the most up to date information recorded.

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:
On the day of Inspection one service users PCP was out of date by approximately 6 weeks, 2 previous dates had been arranged with the family but were cancelled due to the family being unavailable. This has been scheduled for Q1 2022

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
On the day of Inspection one new staff member was not MAPA trained this had been arranged as part of the induction however they were unable to attend due to annual leave. Some regular Agency staff are not currently MAPA trained they will be added to the training list for MAPA with Resilience MAPA trainer in January 2022

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
On the day of Inspection the Inspector highlighted an NFO6 that had not been submitted as a Safeguarding. This was submitted by the manager in retrospect on the day of Inspection .

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
As discussed with the Inspector on the day of Inspection recent staffing vacancies and dependency on agency staffing has seen some inconsistency in systems being carried out. This has been addressed at team meetings and an email to the staff team, a folder for all communication has been put in place for agency staff and emails sent to staff team are read and signed by them.

Relating to one service user a review with the SLT will be requested to look at communication systems that may support the s/u to make informed decisions around their own health.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/01/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/09/2022

	are of sound construction and kept in a good state of repair externally and internally.			
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.	Substantially Compliant	Yellow	31/03/2022
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.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	31/01/2022
Regulation 28(3)(a)	The registered provider shall make adequate	Substantially Compliant	Yellow	31/01/2022

	arrangements for detecting, containing and extinguishing fires.			
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	31/01/2022
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Substantially Compliant	Yellow	31/12/2021
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	31/01/2022

Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Substantially Compliant	Yellow	31/01/2022
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	31/01/2022
Regulation 05(6)(b)	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	Substantially Compliant	Yellow	31/03/2022

	needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
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.	Substantially Compliant	Yellow	31/01/2022
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	08/12/2021
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her	Substantially Compliant	Yellow	31/01/2022

	disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
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	31/01/2022