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:	Grattan Lodge
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	25 March 2025
Centre ID:	OSV-0003599
Fieldwork ID:	MON-0044413

About the designated centre

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

Grattan Lodge is a designated centre operated by St. Michael's House. It is a community based home with the capacity to provide full-time residential care and support to six adults both male and female. It is currently home for six residents with varying degrees of intellectual and physical disabilities. Residents in the centre are supported with positive behaviour support needs, augmentative communication needs, emotional support needs, specialised diet and nutritional needs, and physical and intimate care support needs. The house is situated on a quiet cul de sac with a large green area opposite the house. It is located in a suburban area of Co. Dublin with access to a variety of local amenities such as a local shopping centre, cinema, bowling alley, dart station, bus routes, and churches. The centre has a vehicle to enable residents to access day services, local amenities and leisure facilities in the surrounding areas. The centre consists of a large two-storey house with seven bedrooms and an accessible front and back garden. Residents in the centre are supported 24 hours a day, seven days a week by a staff team comprising of a person in charge and social care workers.

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 (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 25 March 2025	08:55hrs to 17:50hrs	Kieran McCullagh	Lead
Tuesday 25 March 2025	08:55hrs to 17:50hrs	Orla McEvoy	Support

What residents told us and what inspectors observed

This unannounced inspection was conducted to evaluate the quality and safety of care provided to residents. It was prompted by an increasing pattern of safeguarding notifications received by the Chief Inspector. Since November 2024, a total of 48 notifications had been submitted to the Office of the Chief Inspector.

Inspectors determined that, overall, residents received high-quality care provided by a familiar staff team who delivered it with kindness and respect. However, there were areas of non-compliance found relating to the notification of incidents and complaints management. Furthermore, improvements were required under a number of other regulations, including staffing, governance and management, positive behaviour support and protection. These are all discussed further in the main body of the report.

Upon arrival at the designated centre, inspectors were welcomed by a member of staff. They also had a brief opportunity to meet with the person in charge, who mentioned having a very busy morning and was scheduled to attend an important individual case management meeting relating to one of the residents in the designated centre. The person in charge advised that all required documentation was accessible for review in the office. Inspectors therefore conducted a documentation review at the designated centre during the morning of the inspection.

The centre was registered to accommodate six adult residents. During the inspection, inspectors had the chance to meet with all residents. The centre comprised of six single occupancy bedrooms, a kitchen / dining room, a sitting room, a staff bedroom / office, a utility room, a store room, a bathroom and a wheelchair accessible shower / bathroom. Residents' bedrooms were arranged in a way that reflected their personal preferences, featuring items of interest to them. Inspectors observed that residents had unrestricted access to both indoor spaces and the garden. There was sufficient private and communal space, along with adequate storage facilities.

During their visit, inspectors noted that additional cleaning was required in the centre. For example, residue from the guinea pig's enclosure was found on the sitting room floor, the stairs required hoovering, and one fridge in the kitchen was visibly unclean. Additionally, several food items stored in the fridge were not correctly labelled once opened. Furthermore, inspectors identified some minor maintenance issues that needed the provider's attention. For instance, the flooring in the hallway was damaged and needed replacing, while the kitchen floor and bottoms of some of the kitchen cabinets were visibly damaged and also required replacement.

As the other residents had already left for their day service or individual activities, the inspectors had the opportunity to sit and chat with one resident who was being

supported by a student social care worker. The resident spoke to inspectors about their plans for the day, which included going for a coffee and attending the local gym. They showed the inspectors the pets in the house, including a guinea pig and some fish. They shared with the inspectors that they were happy living in the home, felt safe, and were satisfied with the support they received from staff.

In the afternoon, after residents returned from their day service programs and individual activities, inspectors had the opportunity to sit and talk with them. Residents, who had a range of communication support needs, were assisted by staff to interact and communicate with the inspectors as needed. Four residents expressed to inspectors that they were happy living in the home. One resident shared their hobbies and interests, including playing football, going to the gym, and maintaining their fitness. Another resident spoke about their enjoyment of life at the centre, mentioning activities such as attending college, getting their hair done, and participating in their day service program. A third resident, told inspectors they appreciated the support of the staff, enjoyed going out on weekends and to the cinema, and had especially loved going on holiday last year.

However, another resident told inspectors that they did not like living in the centre and wanted to move. They mentioned that they only ''sometimes'' got along with everyone in the home. The resident also shared that they had visited the Director of Adult Services to discuss moving. The resident informed inspectors that they needed someone to accompany them when going out of the centre and they didn't go out independently. They explained they felt panicked and anxious going out on their own and that they had pre-existing mental health need which contributed to this. The resident shared that they were currently on medication to help manage their condition. They mentioned that they got angry when upset, sometimes biting their hand, and had occasionally raised their voice at the other residents.

The inspectors took the opportunity to sit down and meet with the person in charge after they returned from their meeting. A discussion took place regarding the safeguarding notifications submitted to the Chief Inspector of Social Services, as well as the assessed needs of residents and their changing needs. Inspectors noted that residents led active and busy lives, with staff providing support to help them participate in activities of their choice. However, inspectors also raised concerns with the person in charge regarding the notification of incidents, management of complaints made by residents, as well as aspects of record-keeping and reporting practices in the designated centre. This is discussed in full throughout the body of this report.

It is important to note that throughout the inspection inspectors observed warm and positive interactions between residents and the staff caring for them. On the day of the inspection, residents appeared relaxed and comfortable in the designated centre. Staff engaged with them in a kind and friendly manner, demonstrating a strong and supportive rapport.

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 to each resident living in the centre.

Capacity and capability

This section of the report presents the inspection findings regarding the leadership and management of the service, and evaluates how effectively it ensured the provision of a high-quality and safe service.

The service was led by a capable person in charge and they were supported in their role by a service manager. They had a comprehensive understanding of the residents' and service needs. Staffing arrangements required review, as there was one full-time equivalent social care worker position vacant. Inspectors found there was an over-reliance on relief staff to cover these vacant shifts, which was not ensuring continuity of care and support to residents. This had also been raised as a concern during the previous inspection in February 2024.

Staff were in receipt of training to enable them to provide safe and effective care and support in key areas including, fire safety and safeguarding of vulnerable adults. However, on the day of this inspection staff had not received recent training in positive behaviour support and there was no documentary evidence on file relating to scheduled refresher training. Furthermore, not all staff had received formal supervision, which was not in line with the provider's policy.

Some improvements were required in relation to the governance and management systems in this designated centre. Required three day and quarterly notifications had not been submitted to the Chief Inspector, in line with regulatory requirements. Inspectors identified that a comprehensive review was required regarding all lodged complaints in the designated centre. A number of complaints had been opened, but there was no clear record of follow-up or resolution for some of them. Inspectors also noted the need for improvements in the ongoing auditing and monitoring of the designated centre to ensure that an effective quality assurance system was in place.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

On the day of the inspection the provider had ensured there was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times in line with the statement of purpose and size and layout of the designated centre.

The person in charge was supported in their role by a service manager. They were fully responsible for managing this designated centre and were not additional to the roster. The person in charge told inspectors they had established specific managerial hours to meet regulatory responsibilities. The staff team was comprised of social care workers. Inspectors spoke to the person in charge, and to two staff members on duty, and found that they were all knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

At the time of the inspection, there was one full-time equivalent social care worker position vacant. The person in charge was working to ensure the consistent deployment of regular staff. However, a review of the rosters for January, February and March 2025 showed an over-reliance of the use of relief staff to cover vacant shifts. For instance, in January, a total of 11 different relief staff covered 34 vacant shifts, in February, 10 different relief staff covered 34 shifts, and in March 2025, 11 different relief staff covered 26 shifts. This required review by the provider in order to ensure continuity of care for residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors reviewed the most recent staff training matrix maintained in the designated centre. The staff team had current training in mandatory areas including, fire safety and safeguarding. However, 60% of the staff team had not completed recent training in positive behaviour support, with certifications expiring in October 2023, September 2024 and December 2024. It was observed that refresher training had not been arranged for these staff members by the time of the inspection. This presented a risk to the staff members providing person-centred, safe, and effective support to residents with identified positive behaviour support needs, and required review by both the provider and the person in charge.

The person in charge was responsible for the provision of supervision and support to all staff members within the designated centre. Inspectors reviewed one professional supervision template record provided by the person in charge. The agenda covered topics such as supporting individuals, future learning plans, teamwork and interpersonal relationships, staff physical and emotional wellbeing, as well as other issues or concerns. Additionally, staff were also given the opportunity to provide feedback and raise any concerns.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors noted that while clear lines of authority and accountability were in place within the designated centre, this inspection highlighted a number of key areas where improvements were required in oversight and local management systems. Specifically, enhancements were needed in the documentation and reporting of incidents, as well as in the handling of safeguarding information, submission of notifications, and the management of complaints lodged by residents.

An annual review of the quality and safety of care for 2023 was completed, which evidenced that all residents, family members and staff were all consulted in accordance with regulatory requirements. The service manager presented evidence to inspectors that the annual review of care and support for 2024 was currently in progress and due for completion in April 2025. Feedback from residents indicated that the past year had been challenging, with "too many arguments", while one resident expressed a wish to move to a new house. On a positive note, other residents shared that they were happy living in Grattan Lodge, appreciated the staff team, and enjoyed taking part in house meetings, including meal preparation and planning weekly activities.

In addition to the annual review of the quality and safety of care, a number of local audits had been conducted, including those on infection prevention and control, health and safety, residents' finances, and medication. However, inspectors noted that improvements were required. For instance, the person in charge was required to complete and submit local audits on a monthly basis to their service manager. However, upon review, inspectors found that these audits had not been completed from April to December 2024. Additionally, the local audits for January and February 2025 were missing crucial information related to safeguarding, recorded incidents, residents' finances, lodged complaints, and restrictive practices. This required review to ensure the provider and person in charge fully recognised the importance of quality audits in shaping an effective quality improvement strategy and that service delivery remained safe and effective.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

During the inspection, it was identified that the required notifications to the Chief Inspector were not submitted as mandated. Specifically, incidents involving the use of restrictive procedures such as physical, chemical or environmental restraints during quarters 2 and 3 of 2024, as required by Regulation 31(3)(a).

Additionally, it was identified that not all required notifications had been submitted to the Chief Inspector within the regulatory required three working days of any serious injury to a resident that required medical or hospital treatment, as required by Regulation 31(1)(d).

These identified gaps demonstrated the requirement for a thorough review and

consideration by the person in charge to ensure that all relevant adverse incidents were reported to the Chief Inspector in the recommended formats and within the specified timeframes.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors found that the provider had not established or implemented an effective complaint handling process, which hindered the ability to achieve the most appropriate outcomes for residents.

There were gaps in how complaints were managed and how outcomes were tracked. On the day of the inspection, there were five unresolved complaints that had been submitted by various residents to the complaints officer. Inspectors conducted a comprehensive review of all open complaints on the day of the inspection and found that they were not being managed in line with the provider's established policies and procedures.

For example, four of the five open complaints lacked documented dates or any associated actions to be taken in order to resolve them. Additionally, there was no evidence on file showing that the complainants had been provided with a response within five working days, which was required by the provider's policy.

Furthermore, a resident had expressed dissatisfaction with the result and outcome of their complaint. In line with the provider's policy a "Managing an Expression of Dissatisfaction / Complaint" form was completed and dated 12 November 2024. The complaints officer was required to prepare a report outlining decisions, recommendations, and next steps. However, there was no documentary evidence on file to indicate that this had been completed.

Judgment: Not compliant

Quality and safety

This section of the report provides an overview of the quality and safety of the service provided to the residents living in the designated centre.

Overall, a good quality of service was provided to all residents, and during this inspection, inspectors observed residents expressing their choices to staff regarding what they wanted to do and when they needed support. However, improvements were required in relation to risk management procedures, positive behavioural

supports and protection.

The provider and person in charge understood that positive risk-taking was central to good practice and was a key aspect of all residents' growth and development. All residents had individual personal risk assessments on file. However, these required review by the person in charge to ensure that clear documentation, including accurate and appropriate risk assessments supported how residents were assisted in making informed decisions and to mitigate against identified known risks.

As stated earlier in the report, not all staff members had completed recent training in positive behaviour support and this posed a risk to staff's ability to provide person-centred, effective, and safe support to residents with identified positive behaviour support needs. Inspectors noted that while psychology support and positive behaviour support plans were on file, some of these plans were overdue for review. Additionally, inspectors identified during th inspection that a small number of restrictive practices were being used, which had not been notified to the Chief Inspector.

There were processes in place to ensure that every resident had the right to feel protected and safe from harm. For example, the provider had a comprehensive safeguarding policy, and staff were in receipt of up-to-date safeguarding training. However, inspectors identified that improvements and ongoing review was required in the recording and reporting of safeguarding incidents occurring in the designated centre.

Regulation 26: Risk management procedures

The provider had an "Integrated Risk Management" policy in place, with the next scheduled review set for June 2026, which was reviewed by inspectors. The provider had ensured that the policy included all necessary information in accordance with regulatory requirements. For instance, it contained detailed information on managing the unexpected absence of a resident, accidental injuries, self-harm, and outlined the systems in place within the designated centre for the assessment, management, and ongoing review of risk.

All residents had individual personal risk assessments on file, which detailed the identified risks, the existing control measures in place, and any additional actions required to further mitigate those risks. Inspectors completed a thorough review of 12 individual personal risk assessments and found that none of them had an assigned person responsible for the agreed actions. Additionally, there were no documented dates for review of any control measures in place. This presented a risk to the effective management and assessment of risks within the designated centre, as it directly impacted the ability to monitor and address risks appropriately.

Furthermore, this was inconsistent with the provider's established risk management policy, which explicitly required that all risk assessments documented the person responsible for the agreed actions or controls, along with a specified date for the

review of both the risk assessment and it's associated control measures.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Inspectors observed that arrangements were in place to deliver positive behaviour support to residents with identified needs in this area. For example, residents had psychology support and positive behaviour support plans on file. Inspectors reviewed four residents' support plans and found that information was comprehensive and detailed, with all plans developed by appropriately qualified individuals. Additionally, plans incorporated anticipatory strategies and proactive measures to minimise the risk of behaviours that challenge.

However, some improvements were required. For instance, three out of the four support plans reviewed by inspectors were found to be overdue review. This presented a risk to the staff team not having the most current and accurate information, potentially affecting their ability to address and reduce the risk of behaviours that challenge from occurring.

Inspectors noted that processes were in place to manage the use of restrictive practices used in the designated centre. For instance, restrictive practices were consented to by residents, reviewed by the provider's restrictive practice committee, documented, and involved appropriate multidisciplinary professionals in their assessment and development. However, during the inspection, inspectors identified a small number of additional restrictive practices that had not been documented by the person in charge. Furthermore, these had not been notified to the Chief Inspector and had not been approved for use by the restrictive practice committee, as per the provider's policy.

Judgment: Substantially compliant

Regulation 8: Protection

Since November 2024, a high number of safeguarding notifications had been submitted to the Chief Inspector. Inspectors reviewed records of incidents, including daily notes and discussions with the person in charge. They observed that there were ongoing safeguarding concerns in the designated centre and confirmed that preliminary screening forms were completed and submitted to the National Safeguarding Office.

However, improvements were required to ensure that all preliminary screening forms were submitted consistently, in line with best practice and the provider's

policy. For instance, an incident which occurred on 23 February 2025, was not reported to the National Safeguarding Office until 18 March 2025. In addition, inspectors identified two other preliminary screening forms for incidents from January 2025 that were only reported to the National Safeguarding Office on 25 March 2025.

On the day of the inspection there were 11 interim safeguarding plans on file, all of which were reviewed by the inspectors. Following review, inspectors found that there were no dates recorded for reviewing actions, no status updates, and no progress recorded on any of the interim safeguarding plans. This posed a risk for ensuring the most current and accurate information was recorded to effectively manage and mitigate the actual risks in the designated centre and required thorough review by the person in charge.

Following a review of three residents' care plans, inspectors found that safeguarding measures were effectively in place to ensure staff provided personal care in accordance with the residents' care plans and with dignity.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Grattan Lodge OSV-0003599

Inspection ID: MON-0044413

Date of inspection: 25/03/2025

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: The Service Manager and Person in Charge review the roster Each Month to Ensure Permanent staff are on Each day and that consistency of Care is provided. A Roster Review was Held on the 10/04/2025 by the Person in Charge, Service Manager and Administration Manager. A specific Purpose Campaign was Advertised on the 23/04/2025 to Recruit Staff for Grattan Lodge. Administration Manager contacted the Relief Co ordinator on the 16/04/2025 and specific Relief Staff were Identified to cover Vacancies on a regular Basis.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 3 staff are booked in for initial PBS training on the 7th and the 28th May, 4th and the 25th June. 9th and the 30th of July. 2 staff are booked for refresher PBS training on the 12th of June and the 11th of September 202. All staff Supervisions are Scheduled for 2025	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Pathway for Safeguarding is Clearly Identified for Staff to Follow in Grattan Lodge.

All restrictive practices for Q1 2025 have been submitted onto the HIQA Portal on the 22nd of April. The Person In Charge has Introduced a quarterly notifications log to keep track of all Notifications.

The Person In Charge has entered all 2025 complaints onto a complaints log to keep track of complaints status. All complaints were Reviewed by the Person in Charge and Service Manager on the 14/04/2025. All Complaints are Closed.

The Annual review for the Centre was Completed on the 31/03/2025.

Monthly Data for January, February and March 2025 were Completed and sent to the PPIM on the 14/04/2025. Dates agreed for further Submission for the remaining Months of 2025 and Going forward.

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 and the Service manager have reviewed all Notifications for 2025 on the 14/04/2025

Nf03 Submitted retropstectively for the 14/08/2024 on the 01/05/2025.

All restrictive practices for Q1 2025 have been submitted onto the HIQA Portal on the 22nd of April. The Person In Charge has Introduced a quarterly notifications log to keep track of all instances. The Person In Charge discussed quarterly notifications with staff team at the staff meeting on the 23rd of April 25 so that all staff are aware of notifications that require submitting.

Service Manager and Person in Charge will review Notifications at their Management Meetings

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Person In Charge has entered all 2025 complaints onto a complaints log to keep track of complaints status. All complaints for 2024/2025 were Reviewed by the Person in Charge and Service Manager on the 14th of April 2025.The Complaints are now Closed. All Complaints going forward will be discussed at the Person in Charge and Service Mangers Management Meeting.

The Person In Charge has organised managing complaints training for Staff team on the 29th July 2025
The Person In Charge Completed a thorough Review on the complaint dated the 12th of November and this Complaint is now Closed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk Assessments were Reviewed by the Person in Charge and Service Manager on the 14/04/2025 and discussed with the quality and safety Manager on the 30/04/2025 to ensure they are in line with St. Michaels House Policy.

The Risk Management Policy was discussed at the stafff meeting on the 23rd of April 2025.

The Person in Charge and Service Manager will review all Risk Assessments at their Quarterly Meetings.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge and the Psychology team have reviewed and updated all PBS guidelines and are all in date on the 20/04/2025.
These were discussed at the staff meeting on the 23/04/2025.

The Person in Charge has booked 3 staff for initial PBS training on the following dates, 7th & 28th May 4th & 25th June & 9th & 30th of July.

The Person in Charge has booked PBS training for 2 staff on the 12th of June and the 11th of Sep.

PIC has reviewed all restrictive practices and submitted outstanding restrictive practices to PAMG on the 24/04/2025.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Designated Officer will meet with the staff team on the 22/07/2025 to provide additional training and support to all staff members.

Preliminary Screening Forms and NFO6's will be notified within the 3 day time frame and all Safeguarding Plans to be reviewed within a timely manner. In addition, preliminary screening forms will have a SMART action plan attached and reviewed on an going basis by the Person In Charge and Service Manager to include status update and progress.

Safeguarding Plans will be on the agenda for all staff team meetings.
In addition, a safeguarding tracker document has been Implemented by the Person In Charge into this Designated Centre and will be reviewed by the Person In Charge on a Monthly basis.

On the 27/11/2023 a Safeguarding Audit was conducted in the Designated Centre and is reviewed by the Person in Charge and Service Manager on a regular basis. The date for the next Safeguarding Audit is on the 4th June 2025.

The Person in Charge and Service Manager will review all Safeguarding Plans at their Quarterly Meetings and ensure all documentation is signed and updated.

All Safeguarding Plans were reviewed by the Person In Charge and Service Manager on the 14/04/2025, and updated and signed.

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 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	31/07/2025
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/07/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	31/05/2025

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/07/2025
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	31/05/2025
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	Substantially Compliant	Yellow	30/04/2025

	system for responding to emergencies.			
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	30/04/2025
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	30/04/2025
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	30/04/2025
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is	Not Compliant	Orange	30/04/2025

	informed promptly of the outcome of his or her complaint and details of the appeals process.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	30/04/2025
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.	Substantially Compliant	Yellow	30/04/2025
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	30/09/2025
Regulation 07(4)	The registered provider shall ensure that, where	Substantially Compliant	Yellow	31/05/2025

	restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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	30/04/2025