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

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| Name of designated centre: | Acorn Services |
| Name of provider: | Brothers of Charity Services Ireland CLG |
| Address of centre: | Galway |
| Type of inspection: | Unannounced |
| Date of inspection: | 27 June 2023 |
| Centre ID: | OSV-0005041 |
| Fieldwork ID: | MON-0036103 |

## About the designated centre

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

Acorn Services is registered to provide residential services to 6 individuals with moderate to severe Intellectual Disability and/or dual diagnosis and autism. Acorn services comprises of two premises which include a two-storey house located in a town and a bungalow located in a nearby village. The two storey premises has an annexed one bed apartment where one resident resides and the bungalow is divided to provide the two residents who live in that house with their own separate part of the house. Residents are supported by day and by night by a team of social care and support staff in each of the houses. At night, residents in both houses are supported by overnight sleeping staff, who are available to provide assistance if required. The day to day management of the service is delegated to the person in charge with support from a team leader in each house. In addition, the provider has arrangements in place to provide management support to staff outside of office hours and at weekends.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 5 |

## 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 27 June 2023 | 10:45hrs to 18:00hrs | Mary Moore | Lead |

## What residents told us and what inspectors observed

This unannounced inspection was undertaken by the Health Information and Quality Authority (HIQA) to monitor the provider's level of compliance with the regulations. Overall, the inspector found that this was a well-managed service where the provider and the person in charge monitored the appropriateness, quality and safety of the support and care provided to each resident. However, this monitoring had identified and the provider was aware that the needs of the residents living in one house were not compatible in a shared living arrangement. This was not resolved. In relation to the overall inspection findings the provider generally met the requirements of the regulations but some action was required for some areas to be fully compliant. For example, some review was required of the assessment of risks and of the evacuation procedures in one house.

This inspection was facilitated by the person in charge and the staff members on duty on the day of inspection. The person in charge was clearly able to describe to the inspector how they formally and informally monitored the care, support and services that were provided to each resident. The staff members on duty competently described the day-to-day routines of the house, the support and care provided to each resident and, the challenges that arose to the quality and safety of the service due the absence of compatibility between residents.

Over the course of the day the inspector had the opportunity to spend time in both houses, meet with the staff teams, observe practice and engage with three of the five residents who currently live in this service. On arrival at the first house there was one staff member on duty and two residents were present in the house. A second staff member had accompanied the third resident to their off-site day service. The inspector discussed the planned routine for the day. Residents were due to attend a local gym later in the morning and an arts and craft class in the afternoon. The inspector found that residents had good opportunity to engage in a range of community based activities. Staff and management explored new and different opportunities that residents might enjoy and benefit from. For example, in the second house one resident had just returned from their off-site day service and a horse riding session. The second resident had gone with their support staff to avail of local leisure facilities. A staff member spoken with described one residents love of short holiday breaks supported by staff but described how it had become increasing challenging and difficult to source the facilities that the resident needed with regard to their physical disability.

The assessed needs of the residents included communication differences. Verbal communication was not the primary means of communication for two of the three residents met with. The inspector noted how residents were initially a little reserved but as they relaxed with the presence of the inspector in their home two residents in particular engaged well. For example, one resident responded positively to an enquiry as to whether they would like to show the inspector their bedroom. The resident smiled broadly as the inspector discussed photographs of social and family

events on display.

There was a visual schedule on display in the main kitchen-living area and the staff team told the inspector that this schedule and its proper maintenance was very important to one resident. The schedule communicated the staff members on duty each day and the days that the resident had a planned visit home to family. Staff spoken with clearly understood that if it was necessary to make changes these changes had to be discussed and explained to the resident before the changes were represented on the schedule. This resident used a combination of objects of reference and gestures to communicate to the inspector what was important to them in life. For example, the resident showed the inspector objects that represented how important their faith was to them. Staff confirmed that they supported the resident to attend local mass. The resident shared with the inspector a photograph of a deceased parent that they kept with them at all times indicating the importance to them of home and family. In the evening when the staff on duty were cooking the main meal of the day the inspector enquired of the resident as to whether they enjoyed the variety and the quality of the meals provided. The resident nodded yes in reply. The aroma was certainly appealing.

The provider had issued questionnaires to families seeking feedback to inform the annual review of the service but no completed questionnaires had been returned. However, discussions with management and staff and records seen by the inspector confirmed that residents had regular and ongoing access to home and family as appropriate to their individual circumstances. Some families were regular visitors to the service. The inspector noted that families were invited to attend personal planning meetings, medical appointments and reviews. The person in charge said that their engagement with families and the feedback received was positive. As the inspector was leaving the first house one resident accompanied the inspector out. A staff member on duty said that this was an important routine for the resident as they bid farewell to visitors to their home.

Training on promoting the rights of residents was not yet included in the providers staff training schedule. However, the inspector noted the awareness management and staff had and the practice that supported offering residents choice and control. Representatives of the provider had attended the recent HIQA webinar on the upcoming restrictive practice themed inspections. There were restrictive practices in place and there was some scope to improve the use and oversight of these.

In summary, the residents presented as content, comfortable with the staff members on duty and with the person in charge. The range and complexity of resident needs across both houses was diverse. The provider endeavoured to provide each resident with a good quality of life and the support and care that they needed. However, it was evident to the inspector that the needs and preferences of the residents living in one house were very different and not suited to their shared living arrangement. One resident did have their own annexed apartment. The inspector saw and staff confirmed how they had to be vigilant and actively manage this absence of compatibility every day. However, negative peer to peer interactions had still occurred. This required a timely resolution in the interest of all three residents. In the other house residents also had very different needs but they did

not share the facilities of the house, did not interact, had different routines and were supported by their own staff each day.

The next two sections of this report will present the inspection findings in greater detail, will discuss the governance and management arrangements of the service and how governance and management affected the quality and safety of the service being delivered.

## Capacity and capability

There were management systems in place with clarity on roles, responsibilities and reporting relationships. The centre presented as adequately resourced. The provider consistently collected data about the quality and safety of the service. However, where the data collected had found matters that were impacting on the quality and safety of the service these were not all addressed in a timely manner.

It was evident from discussion with the person in charge and records reviewed that there were formal and informal quality assurance systems that was used consistently to monitor the service. For example, the person in charge had an office nearby but called to the houses at least three times each week. The person in charge had a planned schedule for staff meetings and formal staff supervisions. The person in charge was supported in the management and oversight of the service by a lead social care worker (team leader) in each house who had protected administration time each week. A staff member spoken with confirmed they had access to the person in charge as needed, they could seek advice and raise concerns if they had them. For example, if there was a peer-to-peer incident.

Formal quality assurance systems included weekly reports to the person in charge of the general events in each house and quarterly team leader reports on matters such as accidents and incidents, any changes in needs, restrictive practices and residents' personal goals and objectives. The provider was completing the six-monthly unannounced reviews on schedule. Generally a good level of compliance was found and the auditors sought feedback from residents and staff. However, the inspector noted that where corrective actions were needed such as in response to the absence of compatibility between residents or in response to a complaint that had been received, these matters were not yet resolved.

The staffing levels and arrangements on the day of inspection were as described to the inspector. Oversight was maintained of staff attendance at mandatory, required and desired training.

## Regulation 14: Persons in charge

The person in charge worked full-time and had the experience, skills and qualifications necessary to manage the designated centre. The person in charge was satisfied they had the necessary support from the team leaders, their line manager and the wider management and multi-disciplinary teams (MDT). The person in charge had good knowledge of each resident, their care and support needs and of the general management and oversight of the service.

Judgment: Compliant

## Regulation 15: Staffing

Based on what the inspector observed and discussed with management and staff of the service the staffing levels and arrangements in the service were adequate to meet the number of and the assessed needs of the residents in both houses. For example, there were three staff members on duty each day and two staff on sleepover duty each night in one house as one resident required support from two staff. In the other house there was a minimum of two staff members on duty each day up to 22:00hrs. Staff and management said planning for staff absences such as annual leave could be a challenge but the person in charge had contingencies for this and the provider had a ongoing process off recruitment.

Judgment: Compliant

## Regulation 16: Training and staff development

The inspector reviewed a representative sample of the records of training completed by staff. Based on those records training such as in safeguarding, fire safety, responding to behaviour that challenged, infection prevention and control and, the safe administration of medicines was completed by staff. Attendance at baseline training and refresher training was monitored and this training was, based on records seen, planned or scheduled.

Judgment: Compliant

## Regulation 23: Governance and management

While this was a well-managed service and a good balance was achieved between day-to-day management and oversight and more formal systems of quality assurance, actions needed to resolve matters that impacted on the quality and safety of the service were not always addressed in a timely manner and within the

provider's own timescale. For example, the provider was aware of the absence of compatibility between residents. This was not a recent finding and it was a repeat finding of the provider's own internal reviews. In addition, based on these HIQA inspection findings, internal monitoring systems such as the quarterly reports submitted to the person in charge were not identifying all deficits. For example, where a resident's personal goals were not progressed and the reason for this.

Judgment: Substantially compliant

## Quality and safety

It was evident from these inspection findings that the provider sought to provide each resident with a safe service and a good quality of life closely connected to family and the local community. This was achieved on many levels. However, the absence of compatibility between residents limited the appropriateness, quality and safety of the service.

The inspector saw how residents' needs and abilities differed and the challenges that this could present for residents and staff in the context of their shared living arrangement. For example, one resident was mobile and active and had verbal communication skills. Their peer was not verbal, was more sedentary in their routines and liked to relax and observe the general activity in the house. This absence of compatibility as one resident sought to interact and engage with their peer had resulted in some peer to peer incidents. During one recent incident the resident who was not a verbal communicator had clearly communicated their frustration and the limits of their tolerance with their peer. This safeguarding risk was actively managed every day by staff and was not conducive to the safety and wellbeing of residents.

The staff members on duty were aware of this risk and the ongoing requirement for vigilance. Staff described how they would report and discuss with the person in charge and the designated officer the safeguarding dimension of each incident. Staff confirmed that while the residents might travel together in the service vehicle they were always accompanied by two staff members in response to this and other risks to resident safety that could arise. In general, the systems for the identification, assessment, management and control of risks were consistently applied and the provider was responsive to incidents that occurred. For example, the inspector noted an internal audit had followed up on and ensured that the corrective actions needed with regard to an incident where staff had used an unauthorized and unplanned restrictive intervention were complete. However, explicit risk assessments did not always comprehensively capture the preciseness of the risk that presented or the need for additional controls.

Each resident had a personal plan. Families were invited to planning meetings and had input into the care and services provided. The person in charge confirmed that

they had good access to the members of the MDT and their input was evident in the sample of plans reviewed by the inspector. The personal plan included as appropriate a positive behaviour support plan. There was evidence of regular review, input and support from psychology. A range of restrictive practices were in use and their use was regularly reviewed. However, there was some inconsistency in their use.

Residents were supported to engage in a range of activities and also had opportunities for engagement in their homes. However, better oversight was needed of the progression of resident's personal goals and objectives.

The provider had the required fire safety systems in place such as a fire detection and alarm system, emergency lighting and doors designed to contain fire. Regular simulated evacuation drills were completed. However, a review of the escape routes and the evacuation procedures was required in one of the houses.

## Regulation 11: Visits

Based on what the inspector read and discussed residents had ongoing contact with family and this was important to them. Some residents had regular scheduled visits to home and other families were regular visitors to the houses. If privacy was needed or requested, there were suitable rooms that could facilitate this.

Judgment: Compliant

## Regulation 13: General welfare and development

Based on what the inspector observed, read and discussed residents were supported to be out and about in their local community and to engage in a range of programmes and activities. Suitable transport and staffing levels to manage risks that could arise were in place. However, as discussed in the body of this report improvement was needed in the tracking of residents' personal goals and objectives particularly where these were not progressed. In addition, residents' abilities and developmental needs were different and not suited to their shared living arrangement meaning the service was not the most appropriate with regard to the nature and extent of each resident's ability and disability. These deficits are addressed in Regulations 5 and 8.

Judgment: Compliant

## Regulation 18: Food and nutrition

With regard to the assessed need and abilities of residents the staff team prepared and cooked residents' meals. Staff were seen to offer residents choice. A resident confirmed that they liked the meals the staff prepared and cooked. Residents were supported to participate for example in the grocery shop. Staff regularly monitored resident body weight and there were plans in place to support any nutritional needs and requirements.

Judgment: Compliant

## Regulation 20: Information for residents

The residents guide was seen to be available to residents. The residents guide contained all of the required information such as information on how to make a complaint and the centres visiting arrangements.

Judgment: Compliant

## Regulation 26: Risk management procedures

The risks that presented in the service were known and there were controls in place to manage these risks such as staff supervision, positive behaviour support plans and restrictive practices. However, some risk assessments were somewhat generalised. For example, one resident did have a safeguarding risk assessment but there was no risk assessment specifically for the absence of compatibility between residents and the fact that the provider had identified the need for additional controls that were not yet in place. The safeguarding risk assessment did specify the need for staff supervision in the house and in the community for a specific reason. The risk assessment needed to highlight however that there were in effect two risks. Firstly, that the resident could quickly leave the house or the company of staff when in the community as had happened which then may give rise to opportunity for other risk based behaviour.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

Based on the records seen by the inspector staff and residents participated in regular simulated evacuation drills and overall good evacuation times were reported. However, in one house a review of the available escape routes and the night-time

evacuation procedure was needed. For example, in the apartment a door was provided from the bedroom to the corridor of the main house so that the bedroom was not an inner room. However, the door was locked at night and at times by day to segregate the apartment from the house. While continuing to provide the resident with the security and privacy they needed the provider also needed to ensure that this alternative means of escape was highlighted and always readily accessible in the event of an emergency. The provider also needed to be assured that it was a suitable means of escape if needed for the resident who was a wheelchair user. Based on the evacuation records seen the provider needed to repeat the night-time evacuation scenario. This was required to re-test the ability of one staff member to evacuate all three residents (all of whom required some assistance from staff), see how long it took to bring all three residents to a safe location, if corrective actions were needed and, satisfy itself as to the safety and adequacy of the achievable evacuation time.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Better oversight was needed of the progression of residents' personal goals and objectives. One resident's personal plan did not provide evidence of the progression and achievement or not of all of the resident's agreed personal goals and objectives for 2022. There was no evidence that where challenges or obstacles had arisen to achieving these goals, the providers process for reporting such obstacles had been utilised. A staff member spoken with confirmed that all of the residents goals had not been achieved.

Judgment: Substantially compliant

## Regulation 6: Health care

The assessed needs of residents included healthcare needs. Staff monitored residents' health and wellbeing and ensured residents had access to the clinicians and services that they needed including screening and vaccination programmes. There was documentary evidence that residents had access as needed for example to their general practitioner (GP), psychology, psychiatry, dentist and optician. Nursing advice and support was available for within the organisation, for example, in the compilation of healthcare plans. Clinical reviews included the review of any prescribed medicines. Families were invited to attend clinical appointments and reviews.

Judgment: Compliant

## Regulation 7: Positive behavioural support

In response to risks arising there were restrictive practices in use. These were predominately environmental restrictions such as restricted access to certain items. The supporting risk assessments were in place as was evidence of the review of these practices by the providers human rights committee. However, there was inconsistency in the use of and the oversight of restrictive practices. For example, a recent internal audit had identified a restrictive practice that had not been reported as such. This HIQA inspection also identified a practice that met the benchmark for a rights restriction but had not been identified and processed as such. Records seen stated that some restrictive practices such as a resident's access to personal items were to be used only at night-time but based on these inspection findings they were restricted at all times. The impact of the restrictions on others such as the alarm on the front door needed to be considered.

Judgment: Substantially compliant

## Regulation 8: Protection

In the context of their shared living arrangement there was an absence of compatibility between the needs, abilities and preferences of residents. This absence of compatibility created a risk to the physical and psychological wellbeing of residents and required vigilance on behalf of the staff team to prevent negative peer to peer incidents. Incidents had however occurred and the provider had identified the need for more robust action to promote and protect the safety of residents. This was a not a new matter with records seen from 2021 and early 2022 referring to the appropriateness of a resident's living arrangements and the requirement of staff to continuously supervise and redirect residents.

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 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Acorn Services OSV-0005041

## Inspection ID: MON-0036103

## Date of inspection: 27/06/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| Regulation Heading | Judgment |
|---|---|
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A review of the compatibility issues in Acorn Services was undertaken by the Person in Charge, Persons Participating in Management and Senior Managers in July 2023. As a result a plan has been in put in place to address these issues. This plan is outlined under Regulation 8 – Protection below. Person in charge will complete a full review of all residents' personal goals to ensure they are progressing as required and where there are barriers that this is identified and recorded. Going forward Personal Goals will be a standing agenda item on team meetings and they will also be audited by Team Leader and Person in Charge as part of their quarterly audit schedule. | |
| Regulation 26: Risk management procedures | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>A full review of all risk assessments is to be completed by the Person in Charge to ensure all risks are identified and risk assessments are specific to each identified risk. A schedule for review has been completed by the Person in Charge to ensure risk assessments are regularly reviewed and updated where required.<br>A risk assessment has been completed in relation to the absence of compatibility between residents and identified the required controls which are currently in place and the additional controls required which form part of the plan as outlined under Regulation 8 below. | |
| Regulation 28: Fire precautions | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 28: Fire precautions:<br>In order to comply with fire regulations and due to the fact the bedroom in the | |

apartment is an inner room a magnetic access control system will be placed on the doorway into the main house. This system will allow the door to automatically unlock in the event of a fire. This will allow the resident access to an alternative means of escape from the apartment. Following review of fire drill completed in January 2023, there was an identified cause for the lengthy evacuation. A successful night-time fire drill with minimum staffing has been completed on 21/07/2023 to ensure that all residents can be evacuated to a safe location. Time for evacuation was reduced from previous drill ad no corrective actions were identified. A schedule has been put in place by the Person in Charge to complete regular night-time minimum staffing drills over the coming months to ensure that corrective actions that are identified are addressed.

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| 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:
Person in charge will complete a full review of all residents' personal goals to ensure they are progressing as required and where there are barriers that this is identified and recorded. As part of this review the Person in Charge will ensure the names of those responsible for pursuing objectives in the plan are identified and a timeframe is also evident. Going forward Personal Goals will be a standing agenda item on team meetings and they will also be audited by Team Leader and Person in Charge as part of their quarterly audit schedule. A reliable interview on personal outcomes within Acorn Services will also be completed by an external person to the service in August 2023.

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| Regulation 7: Positive behavioural support | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A full review of all restrictive practices will be completed by Person in Charge to identify all restrictive practices within Acorn Services. All identified restrictions will then be processed as per local policy and procedure. In doing this review it will also identify the impact of any restrictions on others within the service.

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| Regulation 8: Protection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
A review of the compatibility issues in Acorn Services was undertaken by the Person in Charge, Persons Participating in Management and Senior Managers in July 2023. As a result of this review a plan has been put in place to relocate one individual from Acorn Services to an alternative living accommodation. A property has been identified however it requires substantial works. A schedule of works for renovation has been completed by the Facilities Department. Person in Charge and Persons Participating In Management have also met with family members to commence discussions regarding the potential moves and will continue to liaise with families and residents as this plan progresses. In the interim staffing levels have been increased in the recent past to allow adequate staff support to all residents and provide 1:1 support to one resident.

## 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 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. | Substantially Compliant | Yellow | 31/01/2024 |
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, | Substantially Compliant | Yellow | 31/08/2023 |

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| | management and ongoing review of risk, including a system for responding to emergencies. | | | |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Substantially Compliant | Yellow | 21/09/2023 |
| Regulation 05(7)(c) | The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales. | Substantially Compliant | Yellow | 31/08/2023 |
| Regulation 07(5)(c) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used. | Substantially Compliant | Yellow | 31/08/2023 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 31/01/2024 |