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:	Community Residential Service Limerick Group H
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	03 and 08 March 2021
Centre ID:	OSV-0005295
Fieldwork ID:	MON-0031680

About the designated centre

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

Community Residential Service Limerick Group H full-time residential care to up to eight residents at any one time. The designated centre supports residents with intellectual disabilities. The centre comprises of two houses based in Limerick. Both houses are two storey in design and contain four resident bedrooms. Residents in both houses have access to well maintained and accessible front and rear gardens for recreational purposes. Residents are supported in the centre; when not attending their day services, by a team of health care assistants and social care staff in the evenings, weekends and holiday periods. Where residents require nursing care due to their assessed needs, it is provided by nurses based in the organisation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 3 March 2021	10:00hrs to 15:30hrs	Lisa Redmond	Lead
Monday 8 March 2021	10:30hrs to 17:00hrs	Lucia Power	Support

What residents told us and what inspectors observed

From what residents told inspectors and what was observed, it was evident that residents' rights were not always promoted and protected, and that their voices were not always heard. It was evident that significant improvements were required to ensure that residents' dignity was respected, and that effective governance and oversight arrangements were put in place to improve the quality of service and lived experience for residents.

An inspector visited one of the two houses in the designated centre, where they met with the four residents that lived there. One of the residents showed the inspector around their home. The resident's bed was damaged however a new bed had been ordered and was due to be delivered after the inspection. The person in charge told the inspector that since the previous inspection in November 2020, two new windows had been ordered and were due to be installed when the COVID-19 restrictions allowed. New carpets had also been ordered and were awaiting fitting.

When these residents were previously met with during an inspection by the Health Information and Quality Authority (HIQA) in November 2020, they had highlighted restrictions that had been put in place that they felt were unfair. These restrictions included one resident who was not allowed to go for walks independently, which they had done before the COVID-19 pandemic. This resident told the inspector that this restriction was no longer in place, and that they were happy that they could now go for their daily walk. It was evident that this was very important to the resident.

Another resident had told an inspector in November 2020 that they hadn't been allowed to go clothes shopping when the shops had reopened. The resident told the inspector that after the inspection, they had gone shopping. Due to the level 5 restrictions that were in place at the time of the current inspection, the resident was now regularly shopping online.

During the inspection, inspectors identified that residents were still subject to undue restrictions, with no clear rationale for why these restrictions had been implemented. For example, it was documented that a number of residents were not allowed to use the bathroom when they accessed services in community facilities. This was despite a number of these residents having individual support needs such as anxiety and incontinence.

On review of the documentation, it was observed that some phrases used to describe residents' support needs were inappropriate. For example, one resident's daily notes stated that the resident 'had a bad day' and 'started acting up again'. It also noted that the resident had broken items in a 'temper'. Another resident's care plan stated 'I can become moody and rude'. The inspectors observed comments stating that residents were 'argumentative' and 'un-cooperative'. It was also stated that one resident presented with 'oppositional behaviour' and that one resident 'can

be a little lazy'. It was not evident that residents' privacy and dignity was respected in relation to personal communications. There was also no evidence of a behaviour support plan in place for the residents where it was identified that such supports were required.

The inspectors noted in one resident's daily notes that they had made a complaint. However, this was not documented in the designated centre's complaints log. Therefore, the complaint was not addressed in line with the provider's complaints policy which meant that the resident's voice was not heard, and their rights were therefore impacted. It was noted in email correspondence that the day after the complaint was made, a meeting was held with the resident and two staff members to discuss what the resident had said. It was documented that initially, the resident did not want to come into the room to discuss the complaint, and that they had put their head down and refused to answer a question. It also noted that an individual who was the subject of the complaint, was in attendance at this meeting.

It was also seen in the resident's daily notes how they felt after the meeting in relation to the complaint. The resident told a staff member that they found it 'difficult' and that their 'face was red with embarrassment'. It was not evident that the resident had been provided with an opportunity to access advocacy services for the purpose of making the complaint. It was also documented that the resident was very worried as a member of the management team had told them that a staff member had lost their job.

It was identified that staff members were not facilitated to highlight concerns on behalf of a resident. Day service staff members, who were also employed by the provider, documented the resident's complaint in their daily notes and raised the issue to management. In email correspondence, it was documented that management of the designated centre had stated that they felt that day service staff were unintentionally encouraging the resident's behaviour, with regard to making false allegations.

In summary, it was evident that residents were not always supported to make a complaint, and that staff members were not facilitated to highlight concerns on behalf of residents. Therefore residents' voices were not always heard, and their rights were not always promoted and respected. It was observed that documentation did not promote the dignity and respect of each resident as an individual. The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these impacted on the quality and safety of the service being provided.

Capacity and capability

It was evident from the findings of this inspection that the management systems in place were not appropriate to ensure that the service provided to residents was safe, consistent and effectively monitored. Improvements had not been

implemented following the inspections completed by HIQA in November 2020 and July 2019. There was evidence of repeated areas of non-compliance with the regulations, indicating that the registered provider had not used the inspection findings to improve the quality of service provided to residents.

The day before this inspection of the designated centre was due to start, the inspector requested that a number of documents were available for the inspector to review. These documents were required to assess compliance with the regulations and included a request to review documentation relating to an allegation of suspected abuse that had been reported to HIQA. Two documents were not provided to the inspector on the day of the inspection, despite a number of requests for the documentation to be provided. The documentation was submitted to HIQA two days after the completion of the first day of inspection, following discussions with the registered provider.

This inspection had been intended to last one day only but due to the findings on the first day of this inspection, and the registered provider's delay in making documentation available for the inspector to review, it was decided that this inspection would be increased to a two-day inspection. The findings outlined in this report were identified during the two-day inspection.

Following the inspection carried out by HIQA in November 2020, the registered provider submitted a compliance plan indicating how they intended to come into compliance with the regulations. It was stated that monthly supervision meetings would be carried out with the person in charge and the person participating in management, to follow up on the actions required to meet compliance with the regulations. At the time of the inspection, there was no evidence that these meetings had occurred. However, records of these meetings were made available to the inspector after the inspection.

An inspector reviewed the actual and planned roster in the designated centre. On review of the roster, the inspector noted one date where three staff were not on duty. The person in charge told the inspector that they rostered three staff on weekends and weekday evenings. However, they noted that it was not always possible to roster three staff every second Sunday. This was not in line with the designated centre's statement of purpose, which stated that three staff would be on duty on weekends and weekday evenings. It was also identified that a monthly review of the staffing had not been completed by the registered provider in line with the compliance plan submitted by the registered provider to HIQA, after the inspection in November 2020.

It was noted that the statement of purpose available in the designated centre was not the most recent copy of the document. This finding is consistent with the findings of the inspection in November 2020.

Regulation 15: Staffing

The registered provider had not ensured that the number of staff on duty was in line with the statement of purpose. It was noted that three staff were not on duty on one of the dates reviewed by the inspector. It was also identified that a monthly review of the staffing had not been completed in line with the compliance plan submitted to HIQA after the inspection in November 2020.

Judgment: Substantially compliant

Regulation 23: Governance and management

It was evident from the findings of this inspection that the management systems in place were not appropriate to ensure that the service provided to residents was safe, consistent and effectively monitored.

It was also noted that day service staff had raised concerns on behalf of a resident. In documentation reviewed on the day of the inspection, it was noted that effective arrangements had not been put in place to ensure staff members were facilitated to raise concerns.

Judgment: Not compliant

Regulation 3: Statement of purpose

It was identified that the statement of purpose available in the designated centre was not the most recent copy of the document.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had not ensured that all complaints made by residents were dealt with in line with the registered provider's complaints policy. It was identified in one resident's daily notes that they had made a complaint. This was not documented as a complaint in the designated centre's complaints log.

Judgment: Not compliant

Quality and safety

It was evident from the findings of this inspection that there were a number of practices that impacted on residents' rights. Residents were not always provided with therapeutic supports in relation to behaviours that challenge, there was a delay in the identification of concerns raised by residents such as an allegation of suspected abuse, and there was no evidence of advocacy supports for residents to support them to raise complaints and concerns. It was evident that significant improvements were required to ensure residents received a good quality of care and support in their home.

In documentation reviewed, it was observed that two residents had raised concerns about an allegation of suspected abuse. However, it was identified that the allegation of suspected abuse had not initially been recognised as such. This resulted in a delay in the initiation of an investigation in relation to the incident, and the notification of the incident to the relevant statutory body. It was also noted that there were inconsistencies in relation to the incident reported to HIQA, and the information contained in the preliminary screening carried out following the alleged incident.

It was identified that three residents witnessed the alleged incident. Staff members met with the residents individually to seek clarity on the concern raised. It was documented that due to one of the resident's limited communication skills, that they were unable to get an account of events from this resident’s perspective. There was no evidence of communication support or advocacy support being provided to the resident, to support them to communicate their account of the event. At the time of the inspection, which was completed 3 months after the alleged incident had occurred, an investigation into the alleged incident had not been carried out. The registered provider told the inspector that terms of reference for the investigation were being developed and in draft, at the time of the inspection.

The inspectors reviewed a number of residents’ files during the inspection. It was noted that a number of residents were deemed to be at risk of making false allegations about staff members. On review of the documentation, there was limited documented evidence that these residents had made allegations about staff members in the complaints log, incident report book and residents’ daily notes. It was identified that there was no documented plan of care to support residents who were deemed to at risk of making false allegations against staff members.

It was also identified in a number of care plans that residents displayed behaviours that challenge, but that there was no support plan in place to guide staff members on how best to support them. In one incident, staff reported that a resident was argumentative, verbally abusive and refusing to listen to staff. After this incident, the resident told staff members that they could not control their thoughts or feelings. There was no evidence of follow-up for this resident, or evidence to demonstrate how the resident was supported.

It was identified that one resident had recently received a minor burn. Although a risk assessment was in place regarding the hazards in their home, the risk assessment had not been updated to reflect the burn received by the resident.

Regulation 17: Premises

Since the inspection completed in November 2020, the registered provider had ordered two new windows, new carpets and a new bed for one resident. These were due to be installed and delivered after the inspection, when COVID-19 restrictions allowed.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that there were appropriate systems in place for the assessment, management and ongoing review of risk in the designated centre. It was noted that one resident's risk assessment was not updated to reflect a recent burn they had received.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspectors reviewed a number of residents' personal files during the inspection. It was noted that a number of residents were deemed to be at risk of make false allegations about staff members. It was also noted in the residents' personal files that there was no plan of care to support them in making allegations against staff members.

The registered provider had not ensured that therapeutic supports were provided to residents as part of the person planning process. There was no evidence of supports to be provided to one resident, following an incident where they told staff that they could not control their thoughts and feelings. It was also identified that residents displayed behaviours that challenge, but It was identified that there was no documented plan of care to support residents who were deemed to at risk of making false allegations against staff members.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured that all residents were protected from abuse. It was identified that an allegation of suspected abuse had not been initially recognised as such. Therefore there was a delay in the initiation of an investigation in relation to the incident, and the notification of the incident to the relevant statutory body. It was also noted that there were inconsistencies in relation to the incident reported to HIQA, and the information contained in the preliminary screening carried out following the incident.

At the time of the inspection, which was completed 3 months after the alleged incident had occurred, an investigation into the alleged incident had not been carried out. The registered provider told the inspector that terms of reference for the investigation were being developed.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not ensure that each resident's privacy and dignity was respected in relation to personal communications. On review of the documentation it was observed that some phrases used to describe residents' support needs were inappropriate.

It was also noted that residents were subject to undue restrictions, with no clear rationale for why these restrictions had been implemented. Residents were not supported to access advocacy supports, to assist them in raising complaints and concerns in the designated centre.

Judgment: Not 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	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Community Residential Service Limerick Group H OSV-0005295

Inspection ID: MON-0031680

Date of inspection: 03/03/2021 and 08/03/2021

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: The registered provider will ensure a robust system is in place to ensure that staffing is in line with statement of purpose. The enhanced system will include a weekly review of planned and actual rosters by PIC and PPIM for a period of 3 months initially to ensure consistency and compliance with the Statement of Purpose. This will be reviewed monthly by at Centre Governance meeting with the Service manager and PPIM for the centre. The PIC has introduced an amended roster which will support ensuring that staffing in the centre is in line with Statement of purpose. Complete: 30.04.2021	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider in order to ensure an effective governance and management structure is in place has established a Governance and Oversight Team to provide oversight and management of this centre. This will ensure that the residents experience a good quality of life, staff are supported to provide a safe service to residents and will specifically address non compliances within the inspection reports. This team includes members of the Service Executive, MDT and Centre governance and is chaired by the ACEO. Terms of reference have been agreed. This team will meet weekly initially and then monthly, to review progress on its action plan and will remain active until such a time as the centre has completed all action plans and achieved regulatory compliance in	

consultation with the CEO. Weekly updates will be provided to the CEO. The CEO has informed the Board and they will receive updates on progress with action plans.

The registered provider will ensure weekly meeting with the PIC and PPIM and monthly centre governance meetings with the Service Manager, PPIM and PIC. Documentation to record and facilitate these meetings has been reviewed.

A new PIC commenced in the centre on the 12.4.2021 and a structured induction and probation programme is in place in line with Service Policy. This will include weekly meetings with the Service Manager during the induction phase and ongoing weekly meeting with the PPIM. The frequency of these meetings will be reviewed after 3 months.

The registered provider will ensure the Director of Quality & Risk complete a provider audit in the centre to review all previous audits and documentation in the centre and develop an action plan in consultation with the Governance and Oversight team. This will include a review of scheduled audits across the centre and a system to review progress on action plans. These will be reviewed monthly by the Governance & Oversight team for the centre.

An audit was completed on the management and procedures for safeguarding and management of complaints on 8.3.2021 by the Principal Social worker and Quality & Risk Officer and areas for improvement identified and an action plan agreed.
Further workshop training for all staff in the centre is scheduled for 20.04.2021, will include complaints management, promoting and protecting resident's rights, managing allegations of abuse.

An audit of personal plans was completed on the 6.4.2021 by the Director of Nursing and areas for improvement identified and an action plan agreed. All personal plans will be updated under direction of the Director of Nursing This will include feedback and focused workshop training for staff on record keeping and appropriate use of language and documentation.

A review of all behaviour support plans commenced 22.03.21 by Management of Challenging Behaviour Instructor with areas for improvement identified and an action plan agreed. Work has commenced on completion of new behaviour support plans and focused workshop training was facilitated with staff on 14.4.2021

Completion date 30.06.2021

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose:	

The Current Statement of Purpose is available in the centre. This will be reviewed by the Director of Quality & Risk as part of provider audit
Complete 31.05.2021

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The registered provider has completed as audit of the management of complaints in the centre by the Quality and Risk Officer on 08.03.21 and areas for improvement identified and an action plan agreed. Further training on complaints management including workshop review of complaints in the centre scheduled for 20.04.2021.
The registered provider will ensure that service manager and social worker will facilitate 6 weekly advocacy meetings with residents in the centre, commenced 01.04.2021. This will build the capacity of residents to raise complaints and voice their concerns. This will be reviewed in 6 months.

The registered provider will ensure weekly meetings between PIC and PPIM and will include review of complaints in the centre, staff meetings, residents meetings, daily notes. The frequency of meetings will be reviewed after 3 months. The outcome of the meetings will be reviewed monthly by the Governance and Oversight team for the centre.
The registered provider will ensure that complaints will be reviewed at the service advocacy steering comittee.

Complete:31.05.2021

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Replacement bed is in place.
The registered provider will ensure that the replacement windows and carpets ordered will be installed as soon as public health guidance permit. Windows will be fitted 16.04.2021
Measurements for new carpets completed and payment made in Dec 2020. New carpets will be fitted when public health guidance permits.
Completion date: 31.05.2021

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider has ensured that the Risk assessment referred to in the report was updated 29.03.2021.
The registered provider will ensure the Director of Quality, Safety & Risk completes an audit of all risk assessments in the centre and will identify areas for improvement and develop an action plan. All actions identified will be implemented and progress reviewed monitored by PPIM and PIC and monthly by Governance and Oversight Team.
Complete: 31.05.2021

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The registered provider has ensured a review of behaviour support plans for all residents in the centre by Managing Challenging Behaviour (MCB) Trainer. This commenced 22.03.2021. Areas for improvement have been identified and action plans agreed. A workshop was facilitated by MCB Trainer with all staff in the centre, 14.04.2021. This included training on preparing a behaviour support plan and appropriate use of language. All behaviour support plans will be updated in line with MCB training.
The registered provider will ensure that all staff complete HSEland programme "Applying a human based Approach to Health and Social Care".

Progress will be reviewed by PIC and PPIM weekly and will be reviewed monthly by Governance and oversight team for the centre.

Complete: 31.05.2021

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The registered provider has ensured that an investigation of an allegation of suspected abuse commenced on 1 April 2021.

An audit was completed on the management and procedures for safeguarding by Social Worker/Designated Officer, complete 08.03.21. and areas for improvement identified and an action plan agreed. Risk assessments are in place for Trust in Care referrals including protective measures.

An audit of personal plans was completed on the 7.4.2021 by the Director of Nursing and areas for improvement identified and an action plan agreed. All personal care and support plans will be updated under direction of the Director of Nursing. This will include feedback and focused workshop training for staff on record keeping and appropriate use of language and documentation.
A review of all behaviour support plans by MCB trainer commenced 22.03.21. Areas for improvement have been identified and action plans agreed. A workshop was facilitated by MCB Trainer with all staff in the centre, 14.04.2021. This included training on preparing a behaviour support plan, documentation and appropriate use of language. All behaviour support plans will be updated in line with MCB training.

Workshop training for all staff is scheduled for 20 April 2021 and will include protecting and promoting resident's rights, definitions of abuse, and managing allegations of abuse and will be facilitated by Social Worker/Designated Officer.
All staff are required to complete HSEland programme "Applying a human based Approach to Health and Social Care".

Complete: 31.05.2021

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The registered provider has ensured that workshop training has been scheduled for all staff in the centre for 20.04.2021. This will include Complaints process, managing complaints and will use examples of complaints in the centre facilitated by Quality and Risk Officer. It will include Charter of rights for residents, definitions and managing allegations of abuse facilitated by Social Worker/Designated Officer. Training on person centredness will be facilitated by Transforming Lives Project Officer.
The Registered provider will ensure that all staff will complete HSEland programme "Applying a human based Approach to Health and Social Care".

The Quality and Risk Officer and Director of Nursing, will provide feedback and training to staff on record keeping, documentation and principles of person centred approaches in plans of care.

The registered provider will ensure the Service Manager and Principal Social Worker will

co-facilitate advocacy meetings with residents in the centre on a six weekly basis, commenced 01.04.21. This will encourage residents to voice concerns or feedback on the centre and build their capacity to self-advocate and raise concerns. This will be reviewed in 6 months.
Residents will be supported by CNM2/PPIM and Staff Nurse who visit centre weekly and meet with the residents.

The registered provider will ensure Residents meetings will continue monthly and the PIC will co- facilitate these meetings to ensure any issues raised are reported in line with policy and are reviewed by Governance oversight team through PIC and PPIM. A schedule of individual members of the Governance oversight team will attend each months residents meeting to ensure residents' rights are supported and enhanced through this forum. Individual members will feedback on progress to the Governance oversight team. This will be reviewed in 6 months.
One resident in the centre will continue to act as the advocate on behalf of the centre on the service advocacy committee.

The registered provider will ensure an audit of person centered plans by the Transforming Lives Project Officer and identify areas for improvement and an action plan will be agreed. Personal plans will be updated and further developed with the residents to ensure that all residents wishes and preferences are documented. The Transforming Lives project leader will provide staff training on person centred planning including social role valorisaion.
All residents will be referred to independent advocacy service.

The registered provider will ensure the Director of Quality, Safety & Risk completes an audit of all risk assessments in the centre and review of all risk assessments in relation to infection prevention and control measures while accessing community services and facilities.
Risk assessments will be reviewed fortnightly by PIC and PPIM for 6 week period to ensure that no unnecessary restrictions for residents are in place.

An audit of personal plans was completed on the 7.4.2021 by the Director of Nursing and areas for improvement identified and an action plan agreed. All personal care and support plans will be updated under direction of the Director of Nursing This will include feedback and focused workshop training for staff on record keeping and appropriate use of language and documentation.

Completion date 30.06. 2021

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	30/04/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/05/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the	Substantially Compliant	Yellow	30/06/2021

	effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2021
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	30/06/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/05/2021
Regulation 03(3)	The registered provider shall	Substantially Compliant	Yellow	31/05/2021

	make a copy of the statement of purpose available to residents and their representatives.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	31/05/2021
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	31/05/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/05/2021
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed	Not Compliant	Orange	31/05/2021

	consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/05/2021
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	31/05/2021
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	30/06/2021
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her	Not Compliant	Orange	30/06/2021

	disability has access to advocacy services and information about his or her rights.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/06/2021