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:	No 1 Portsmouth
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	21 September 2021
Centre ID:	OSV-0005679
Fieldwork ID:	MON-0034190

About the designated centre

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

The centre provides residential services for a maximum of five adults. It provides support to persons with an intellectual disability, including those who have autism, behaviours that challenge and who may have a dual diagnosis of mental health and intellectual disability. The centre comprised of five separate living areas in a semi-detached bungalow and one stand alone home. The centre is located in a large campus style setting on the outskirts of Cork city. The service can provide support to males and females and utilises the social care model. The centre encompasses a person centred approach and encourages residents to reach their fullest potential in all areas of their lives. The staff in the centre have a varied range of qualifications, skills and experience of supporting people with intellectual disability, which ensures a quality service is delivered to each individual living here. The staff team work a rota system of day and waking nights shifts.

The following information outlines some additional data on this centre.

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 21 September 2021	9:00 am to 3:00 pm	Laura O'Sullivan	Lead
Tuesday 21 September 2021	9:00 am to 3:00 pm	Caitriona Twomey	Support

What residents told us and what inspectors observed

This unannounced risk inspection was completed in No.1 Portsmouth following receipt of solicited information by HIQA. Upon arrival the inspectors observed that building works were in the progress in one of the three units that comprise the designated centre. The inspectors were informed that this was to provide each resident with a self-contained living area. Following knocking at two doors, inspectors were required to telephone the person participating in management to gain entry to the centre. The appointed social care leader met with the inspectors and brought them into one of the units. At this time, the rationale for the inspection was explained to the social care leader.

It was noted that while one resident was in bed in their self-contained area, staff were located in an adjoining area in the unit. Staff were required to open and close an office door with a key to gain entry to both areas of this unit. The social care leader also reported that one staff member had called to say they were unable to report to work that morning. A staff member had not been identified to cover the shift, as a result one staff was working in one area as a lone worker when this had been identified as requiring two support staff as per the residents assessed needs. This staffing level was not in line with the proposed roster for this centre. Following a review of the actual rosters it was noted that this was a regular occurrence.

Staff were observed supporting one resident to prepare for their day. To facilitate building works, two residents had a busy day of activities outside of the house. Inspectors were informed that one resident required two staff to support them. However, this resident was observed leaving the centre with the support of one staff. The other resident living in this part of the centre was supported by their day service staff to go about their day from 10am. They remained in bed until this time.

Inspectors were informed that in this unit a minimum of three staff were required from 10am. However at 9pm, the staffing level was reduced to one. Assistance, if needed, could be obtained from staff working in an adjoining unit (also part of this centre). It was noted in records that both residents were regularly awake until after midnight, but no record was maintained if additional staff support was utilised to allow for review of the assessed needs of the residents. Whilst the provider spoke of the intended plan to introduce additional staff support in sleeping hours, an interim plan had not been developed to maintain staff support in the centre as per the assessed needs of the residents.

In another unit allocated to the centre, one resident had already left to begin their day's activities before the inspectors' arrival. Another resident was being supported by staff to tend to their personal care to commence their day activities. On arrival, it was noted that signage was present on an external door to ensure that it was locked at all times. However, this door was found to be unlocked. It was also noted that the medication press was unlocked, open and unattended. This was subsequently locked by an inspector and the key returned to the person in charge.

Many areas in this unit were observed to be unclean. The cleaning schedule for the previous night had been signed to say all cleaning had been completed, however the floors were unswept and had not been mopped, the bathroom areas had not been cleaned.Also, the kitchen areas had not been cleaned for example, a dirty frying pan was observed on the cooker hob and food residue in the fridge, coffee stains had not been cleaned from walls or the skirting boards. In the unit that inspectors visited initially, it was noted that the area a resident was provided to eat their meals and relax had not been cleaned following building work. One of the two dining chairs provided was broken. An urgent action was issue to the provider to ensure the premises were cleaned to ensure a safe and clean area was provided to all residents.

At the previous inspection it was noted that the centre was not operated in a manner that was respectful to the residents' rights. For example, the provision of an area for a resident to store their personal possessions in their own space. Practices observed during this inspection showed that actions set out in compliance plan response had not been implemented. It was noted that the resident's clothes remained in a wardrobe in their peer's living space. It was also observed that their clothes were being dried on a clothes horse in their another resident's hallway. Staff continued to walk freely between residents' private living spaces through interconnecting doors rather than using the main entrances to maintain the resident's privacy. Whilst reviewing the area of medication management and guidance for staff it was noted that the terminology used in some documents was not respectful in nature. For example, when referring to the symptoms that a resident may display if unwell, this was referred to on the protocol recording sheet as "acting out". This required review.

Residents required full support from staff to maintain their safety and wellbeing within the centre. When a serious incident occurred there was not clear evidence of adherence to local and national policy. Information presented to the inspectors evidenced that it was ten days after one incident before notifications were made to the relevant statutory bodies. Whilst an interim safeguarding plan had been developed to ensure the safety of residents was maintained, the provider had not ensured the centre was effectively resourced to ensure that the required actions were implemented, this included ensuring staffing levels were maintained.

The next two sections of the report will present the findings of the inspection in relation to the governance and management in the centre and the impact on the residents currently residing in the centre.

Capacity and capability

The inspectors reviewed the capacity and capability of the service being afforded to residents currently residing in No.1 Portsmouth. As previously stated, this was an

unannounced risk inspection completed following receipt of solicited information by HIQA which focused on a cohort of regulations based on the risk identified only. A previous inspection of the centre had been completed in April 2021, which evidenced some compliance in the areas of general welfare and development and activation for residents . Following this, as part of a reconfiguration, two units were added to the footprint of the centre. Subsequent to that inspection a compliance plan response had been received and accepted by HIQA. However, it was noted on this inspection that a number of actions had not been completed. This will be discussed later in the report. The findings on this inspection demonstrated that the governance and management of this centre did not provide effective oversight to ensure that residents were safe and in receipt of a good quality of service.

The registered provider had appointed a governance structure to the centre. A suitably qualified and experienced person in charge reported directly to an appointed person participating in management. A social care leader had been appointed to support the person in charge to oversee the day to day operation of the centre in two of the three units allocated to the centre. They were afforded eight hours a week administrative time to complete their governance responsibilities.

The monitoring systems in place within the centre did not provide effective oversight of the service to ensure the service provided within No.1 Portsmouth was safe and met the assessed needs of the residents. Following a serious or adverse event evidence was not provided of a clear governance review to ensure appropriate measures were in place to ensure information provided was accurate and measures in place to reduce the risk of re-occurrence. For example, following a number of medication errors, an audit of systems had not been completed to identify causative or contributing factors. This had been set out as an action to be completed in a notification submitted to HIQA. A review of incidents had not been completed following previous incidents to learn from errors, to drive service improvements and prevent reoccurrences.

There was evidence of non-adherence to governance responsibilities by set out in organisational policies including the use of CCTV (closed-circuit television). For example, clear signage, a risk assessment and privacy impact assessment were to be in place regarding the use of CCTV, as set out in the organisational policy. This was stated as the responsibility of a member of the governance team. These were not evident or available in the centre on the day of inspection when requested for review.

The registered provider had not ensured that staff were provided with ample opportunities to raise concerns with respect to the service provided within No.1 Portsmouth. Staff were not provided with supervisory meetings in line with the organisation's policy as a tool to discuss issues or concern in a secure environment. Staff meetings had not occurred following two recent significant incidents to discuss these events or support staff team learning from same. A recommendation was made on 09 September 2021 to support staff with the protected disclosure process. On the day of inspection, no actions had been taken to implement this recommendation.

The actual and planned roster reviewed on the days of inspection did not consistently ensure staffing levels in place were appropriate for the assessed needs of the residents. On a number of occasions it was evidenced in the roster that the allocated staffing levels to the centre, this included the day of inspection. Inspectors were informed that one resident required two to one staffing support during waking hours however, on the day of inspection they left the centre with the support of only one staff. Whilst a safeguarding plan had been developed stating that a resident was to be fully supervised at all times, this was not possible due to the staffing allocated to the centre at night.

The statement of purpose document did not accurately reflect the service provided in the centre. The description of all three units was incorrect. The staffing levels allocated to the centre did not reflect the current staffing or shift patterns allocated to the centre. The role of the night supervisor, as reported to inspectors during this inspection, was not reflected in the organisational structure. This required review.

Regulation 15: Staffing

The actual and planned roster reviewed on the days of inspection did not consistently ensure staffing levels in place were appropriate for the assessed needs of the residents.

Judgment: Not compliant

Regulation 23: Governance and management

Evidence on the day of inspection did not provide assurance that effective governance systems were in place to ensure the service provided was safe and appropriate to the residents' needs, consistent and effectively monitored. This included non adherence to the compliance plan submitted to HIQA following previous inspection There was not evidence of monitoring systems in place to identify causative factors and drive service improvement.

Also, evidence was not presented to ensure staff were facilitated to raise concerns about the quality and safety of the care and supports provided to residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development of the Statement of Purpose document. However, this had not been updated to reflect the current status of the centre including descriptions of buildings, staffing levels in place and management arrangements.

Judgment: Not compliant

Quality and safety

The inspectors reviewed the quality and safety of the service provided to the residents currently residing in the centre. Evidence reviewed and observed during the course of inspection did not evidence that the rights of the residents were supported and promoted. As part of the previous inspection, it was noted that the rights of the residents was not promoted in the centre. Following the inspection the provider provided assurances that actions would be completed in a time bound manner to ensure the rights of all residents was promoted. A number of these actions remained outstanding. For example, personal possessions of one resident continue to be stored in a peer's personal area. Their clothes were also observed to be hanging on a clothes horse in another resident's hallway. The use of interconnecting doors had previously been highlighted by HIQA as not promoting a residents rights to privacy. This practice continued to occur, with a number of staff observed to use interconnecting doors, despite stating these were only to use in an emergency. As part of a review of documentation it was noted that the terminology used was not respectful of residents including for example referring to the displaying of medical symptoms as "acting out". This required review.

On arrival to the centre is was noted that one of the units allocated to the centre was undergoing building works to provider each individual with a private living space. An area which had been allocated as an interim dining area for one resident whilst a new kitchen was being installed had not been cleaned since the previous day, with a layer of dust and concrete residue observed on the table area. The social care leader identified that this should have been cleaned upon departure of the builders on the previous day. Upon entering another area of the centre it was noted that the area was unclean. The floors had not been brushed, the bathroom areas and fridges were unclean. The cleaning schedule in place for both areas visited had been signed by staff sitting that all cleaning required had been completed. Given the inspectors' findings with respect to the uncleanliness of the area and the impact of this on residents, an urgent action was issued to the provider to address this.

The registered provider had not ensured that appropriate and suitable practices were in place for the safe administration and storage of medicinal products. On the day of inspection, inspectors were presented with a document detailing six occasions where medications could not be accounted for between September 2020 and January 2021. These incidents had occurred prior to an incident which had in part

prompted this risk inspection. Following the most recent reported medication error, a safeguarding plan had been developed to ensure the personal possessions of resident were appropriately secured and maintained. Actions set out within this safeguarding plan had not been completed in the six weeks following its development. This included an audit on the use of PRN (as needed) medication, the relocation of the CCTV camera to provide a view of the medication press, and the provision of a roller drawer to facilitate medication preparation and counts.

In addition to the non-implementation of these required actions, a number of noncompliant actions in the area of medication management were observed on the day of this inspection, a medication press was observed by inspectors to be open and unattended. This unit's main door was unlocked, therefore access to the contents of the medication was open to all. Following a review by an inspector, it was noted the protocols for as required medication (PRN) did not provide clear guidance to staff. An excess volume of PRN medication was observed to be present in the centre. Training records for the staff allocated to the centre did not provider evidence that all staff had up to date training in the area of medication administration. No governance oversight was evidenced in the area of medicinal products to ensure compliance was achieved and maintained. Actions required had not been identified to prevent reoccurrence of incidents, for example the inspectors observed a number of errors in documentation including stock checks and recording or drug administration.

Overall, following reconfiguration of the centre there was evidence of a decrease in safeguarding concerns in No.1 Portsmouth. The registered provider had ensured the development of a policy to safeguard vulnerable adults from abuse. However, the registered provider had not ensured that each resident was protected from all forms of abuse. An unknown incident had occurred which resulted in the need for medical attention for a resident. Following this significant incident there was not clear evidence of adherence to this policy. A meeting had occurred to discuss the concern on the day following the incident, an interim safeguarding plan had been developed and statements were received from the staff team present. However notification to the relevant statutory bodies did not occur for ten days post the incident. Whilst an interim safeguarding plan had been developed the governance team stated that the incident had not been recognised as a potential protection concern for a number of days. It was also identified that the interim safeguarding plan had not been provided to the staff team in this time. Upon further review it was noted that two varying versions of the interim safeguarding plan were provided to inspectors. One had been submitted to the relevant statutory bodies and the other had been provided to the staff team.

Within both interim safeguarding plans, one action identified that one resident was to be fully supervised at all times. As outlined previously in this the centre was not resourced by the provider to implement this with times evidenced when the resident was unsupervised. Whilst an environmental assessment had been completed this did not provide assurance that all areas of risk had been reviewed appropriately, also taking into account the recent changes to the environment and building work being completed.

Regulation 17: Premises

The registered provider had not ensured the premises were clean. On the day of inspection it was noted that one area of the centre had not been cleaned following the completion of building work to provide an area for a resident to enjoy their meals. Another area of the centre presented as unclean despite the cleaning records being signed to record cleaning had been completed. Issues identified included the following: the fridge was dirty with food residue present on shelving, the floors remained unswept, bathroom areas had not been cleaned. An urgent action was issued to the provider on the day of inspection to address this.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured that appropriate and suitable practices in the centre relating to the storage, disposal and administration of medicinal products.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured that measures were in place to protect all residents from abuse. There was not evidence of adherence to the organisational policy in safeguarding vulnerable adults from abuse. Where a safeguarding plan had been developed actions required to promote the safety of residents had not been implemented.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had not ensured that the centre was operated in a manner that was respectful to the rights of the residents, this included the terminology used in documentation, the right to privacy and access to personal possessions.

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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for No 1 Portsmouth OSV-0005679

Inspection ID: MON-0034190

Date of inspection: 21/09/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The 'Provider has ensured that • The statement of purpose has been updated to reflect the current staffing levels and that a response plan based on alarm activation system is in place to support staff within the designated Centre. • All staffing issues set out in safeguarding plans have been clarified with the Designated Officer and the Team and are rostered accordingly • A contingency plan has been developed where staffing levels cannot be maintained due to short notice staff absence and recruitment issues. This plan is based on one to one staffing per resident plus emergency back-up plan – the Statement of Purpose will reflect this • A MDT assessment currently underway to review the assessed needs of the residents. This will set out what staff support is required for each resident at specific times of the day/activities undertaken. This will be completed by 30/11/21. • The MDT review will include a review of night time staffing levels • Risk assessments around staffing will be reviewed and updated in line with guidance on assessed needs upon receipt of review from MDT. The Provider will adopt a dynamic risk assessment approach to provide appropriate supports as required and to also consider individual staff competencies in supporting individual residents as there is evidence that some residents prefer one staff rather than two staff support. The Provider will identify a pool of staff is available to be called upon to facilitate specific activities where individual residents do not require enhance staffing at all times. [20/12/2021] • The Provider & PIC will continue to work with Human Resources Department on recruitment and retention of staff in these high support areas where careful staff selection is key to the enhanced quality of service provided to residents as evidenced in the past eighteen months for one house in particular. The environmental changes for the remaining residents will also impact on the staffing requirement where the objective is to ensure that the residents have safe supported environments which is responsive to the individual resident's needs without unnecessarily overcrowding with staff where the residents may wish to be afforded the quiet enjoyment of their own homes.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider will ensure that
• The PIC audit schedule in place is applied more frequently and in particular where there are incidents of concern identified. The learning from this monitoring system will be reviewed with the staff team to provide increased awareness, effective oversight within the service and to ensure the service provided is safe. [1/10/21]
• A PPIM audit schedule, to supplement Provider 6 monthly Visits, is in place as a monitoring system to provide effective oversight within the service and to provide additional support to the Person and Charge and the Team in this high support centre. [1/10/21]
• AS this is a period of change for residents who are moving to new apartment living arrangements within the centre staff meetings scheduled weekly from 28/10/21 for a period of two months, thereafter fortnightly.
• The PIC will ensure that staff are supported with supervision sessions both scheduled and by request across the designated centre to facilitate staff to discuss any concerns they may have. [31/12/21]
• The Statement of purpose has been updated to accurately reflect the service provided in the centre including the staffing levels allocated to the centre and the role of the night supervisor.
• A system is in place to ensure that actions identified to improve the service in the Centre are actively reviewed and progressed. On review of outstanding actions from HIQA inspection in April 2021 it was identified this was a result of a number of factors including availability of maintenance contractors, building materials following COVID lockdowns has led to the delay in completion of scheduled works. The Provider has now established that the PPIM meets the PICs on a monthly basis to review designated matters including a review and update of action plans following HIQA inspections and Provider visits. These outstanding actions will be completed by 12/11/21

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of purpose has been updated to accurately reflect the service provided in the centre including clarity on the operation of the apartment settings where facilities and staffing are shared, the staffing levels allocated to the centre and the role of the night supervisor. The Statement of purpose will be submitted to the Authority on completion of the current building works in the Centre to support an Application to Vary the conditions of Registration. [20/12/2021]

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider has ensured that the standard of cleanliness is maintained in the centre and will support the Person and Charge and the staff team in this regard as the specific engagement and tolerance levels of residents to cleaning activities when they are in the Centre can be challenging for the team.
The following measures have been taken
• Issues arising on the day of inspection were immediately followed up i.e. the designated centre was cleaned on the day of the inspection, a deep clean of the centre scheduled and was conducted on 21/09/21.
• Staff have been reminded of the necessity for enhanced cleaning regimes as a fundamental step in combating the spread of COVID 19 infections
• A New cleaning template specific to each area of the centre created detailing times and staff who will do the cleaning.
• A Detailed description of how to clean each area has been created for staff [31/10/2021]
• PIC and Team Leaders have enhanced the system to monitor the cleaning standards daily including identifying the nominated person to monitor in their absence.
• Cleaning and the importance of maintain a clean environment will be entered into the risk register for ongoing monitoring at team meetings.
• PIC will sign off cleaning schedules weekly to ensure compliance.

The Provider will ensure that current building works in the Centre are completed as soon as possible and an Application to Vary will be submitted to the Authority to reflect the revised layout of the Centre [20/12/2021]

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Person in Charge has ensured that
• A Medication audit was completed on 22/9/21 and a resultant action plan was put in place. This was completed on 1/10/21
• The PRN Stock sheet was updated 22/9/21.
• The stock of PRN medications held in the house has been reduced and a protocol re re-ordering etc. is in place
• The CCTV camera equipment installed for security purposes in two offices where medication is stored, has been repositioned to have full view of medication press 22/9/21
• The medication key holder and medication count protocol has been updated on 7/9/21 and reviewed 22/10/21.

• Following finding unlocked medication press, the PIC spoke with all staff individually reminding them of importance and necessity of keeping medication press locked. 30/9/21
• A Working group has been established, to review the following :
· The PRN recording system within the service.
· Review current auditing system and its effectiveness.
· To recommend a standard approach to storage of medications.
· To ensure a standardised approach to medication documentation.
This work is to be completed by 31/1/22 with recommendations to the PIC & PPIM by this date, with a view to implementation of these recommendations by 31/3/2022

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Provider will ensure that
· All concerns reported on Safeguarding Incident Forms are notified to the Authority even if the Designated Safeguarding Person has recommended that they be examined initially as a safety incident.

• Review its incident review procedures to ensure governance and management reviews are evidenced on the incident system.

• A review currently being conducted by an external consultant is concluded on a timely basis and all recommendations implemented.

• The PIC will ensure all staff have received updated training in relation to safeguarding residents and the prevention, detection and response to abuse. This training will include training on Protected Disclosure Procedures [30/11/21]

• The PIC will conduct staff supervision session to facilitate staff if they wish to voice concerns. [31/12/21]

• The PIC is present in house on regular basis each week, meeting with staff and will attend scheduled staff meetings where safeguarding is a standard agenda item, designed to promote a culture of shared learning from incidents and to drive quality enhancement.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Provider will ensure that the plan to create a walk in closet for one resident who will not tolerate their clothing in their bedroom, delayed due to non availability of contractors Building Contractors are on site and the work is now in progress. [12/11/21]

• The staff team will be fully advised of the operational functioning of the apartments within the overall operation of the Centre and how staff should within these settings especially those newly created environments.
• The Provider will ensure that the staff team are clear on how the privacy of individual apartment dwellers is respected by third party individuals visiting the Centre. [30/11/21]
• The Provider will ensure that staff use current versions of template documentation where terminology reflects rights based approach to supporting residents. The documentation has been updated on 22/10/21.

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.	Not Compliant	Orange	20/12/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	20/12/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	20/12/2021

	kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/10/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2021
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	31/12/2021
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal	Not Compliant	Orange	31/03/2021

	and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	20/12/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2021
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.	Not Compliant	Orange	31/12/2021
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	30/11/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with	Not Compliant	Orange	30/11/2021

	his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
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	12/11/2021