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:	Gentili
Name of provider:	ChildVision Company Limited by Guarantee
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	06 June 2024
Centre ID:	OSV-0008149
Fieldwork ID:	MON-0034996

About the designated centre

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

Gentili's service is for vision impaired young people, aged 18 plus, both male and female, including young people who are vision impaired with additional disabilities. Gentili offers four residential places. The primary and main aim of a residential placement in Gentili is to facilitate access to appropriate educational and social provision. Gentili provides social care and support consistent with maximising the young person's educational attainment and holistic development. Gentili provides a high quality standard of care which is responsive to the individual social and emotional needs of the vision impaired young people who live in the house. The centre is managed by a full-time person in charge and staffed by a team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Thursday 6 June 2024	10:00hrs to 17:30hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This announced inspection was carried out as part of the regulatory monitoring of the centre and to help inform a decision on the provider's application to renew the registration of the centre. The inspector used observations, engagement with residents, discussions with staff, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre.

The inspector found that improvements were required under most regulations inspected to ensure that residents were in receipt of a safe, consistent, and quality service that was effectively monitored. However, the inspector observed that residents appeared content in the centre, and staff engaged with them in a kind and respectful manner.

There were three residents living in the centre, and one vacancy. The residents attended various educational programmes during the day, which were delivered on the provider's main campus. The campus was within a short walking distance from the centre. There was also a vehicle available in the centre to transport residents to their day programmes and community-based amenities and services.

The inspector had the opportunity to meet all three residents. The residents had complex communication means, and did not communicate their views with the inspector. One resident shared jokes with the inspector while they played music on their keyboard. Another resident was relaxing in their room, but briefly engaged with the inspector by showing them their toys. Another resident was watching their favourite film in the main living room, but engaged with the inspector by shaking their hand, and with the support from the person in charge briefly spoke about their family and holidays.

The inspector found that communication care plans were not in place for all residents to guide staff on effectively communicating with residents. This matter is discussed further in the quality and safety section of the report.

In advance of the inspection, residents' families had completed surveys on what it was like to live in the centre. Their feedback was positive. For example, the surveys indicated residents were safe, had choice and control in their lives, got on with their housemates, could receive visitors, and were happy with the services available to them in the centre. The comments included "[resident] has loved [their] time in Gentili, staff made [them] feel welcome" and "I never had to worry about [them]", there is "great communication", "I enjoy going to the coffee shop", and "my favourite part is having my own bedroom and bathroom".

The provider's annual review and six-monthly unannounced visit reports of the centre had also given residents (and their representatives) the opportunity to express their views on the service provided in the centre. Two families submitted

positive feedback as part of the most recent unannounced visit, which indicated that they were satisfied with the service provided to residents.

The inspection was facilitated by the person in charge. They told the inspector about residents' varied and high support needs, however also said that they were encouraged to be as active and independent as possible. They said that residents' were content in the centre, and always treated with respect. They also told the inspector about each residents' interests and preferences, such as their favourite foods and hobbies, and demonstrated a good knowledge on these matters. They said that residents' families were free to visit the centre, and that there was good communication with them. They told the inspector about how residents were consulted with. For example, residents had weekly meetings to plan their menu and activities, and discuss any other relevant topics. The inspector read minutes from recent meetings, which noted discussions on the menu, staff rota, fire safety, and the upcoming inspection. One resident also sat on the provider's 'student representative forum'. The forum was attended by the Director of Social Care, and allowed residents to raise concerns from their respective centres.

The person in charge complimented the staff team on the care and support they provided to residents, and was satisfied with the skill-mix. However, they also expressed concerns about how staff vacancies were impacting on residents and staff. This matter is discussed further in the next section of the report. They also told the inspector about some of the improvements in the centre since the previous inspection in November 2023, such as enhancement of the fire safety systems and upgrades to the premises. However, there were issues with the heating system that remained unresolved. They had no other concerns, and was satisfied with the arrangements for them to escalate any concerns to the Director.

The inspector spoke with three permanent social care workers at different times during the inspection about a wide range of matters. They spoke about residents and their needs in a very respectful, warm, and professional manner, and it was clear that they were endeavouring to provide them with good quality care and support. They said that the staff team worked well together, advocated for residents, and knew their individual personalities and needs well, including how they communicated. Some of the social care workers had completed human rights training, and described how residents' rights and dignity was promoted in the centre. For example, residents were always communicated with when staff delivered care interventions (such as intimate care) and applied restrictive practices to ensure that they understood and consented.

They expressed similar concerns as the person in charge about the staff vacancies in the centre, and the associated impact on residents and staff (this is discussed further in the next section of the report). They were familiar with the arrangements for reporting any safeguarding concerns. However, some staff expressed concerns regarding how some behavioural incidents were classed, and the associated risk to other residents. The inspector discussed these concerns with the Director before the inspection concluded, and was given verbal assurances that they would be addressed.

The inspector was shown around the premises by the person in charge. The premises comprised the ground floor of a large two-storey building. The premises included residents' bedrooms with en-suite facilities, staff rooms and an office, and communal spaces including a utility room, a kitchen, and an open-plan living and dining room. The premises were observed to be clean, and contained specialised equipment used by residents such as mobility aids. Residents' bedrooms were decorated to their tastes, and there was communal space for them to receive visitors. The kitchen was well-equipped, and the inspector observed a good selection and variety of food and drinks for residents to choose from.

There was a notice board in the kitchen displaying the weekly menu, staff rota, and information on advocacy, safeguarding, and the HIQA inspection. The inspector also observed that efforts had been made to make the premises more accessible to residents. For example, there were large push buttons at the front exit door for residents with reduced mobility, and residents were provided with fobs to open the door from the outside without the need for a key.

The inspector observed good fire safety precautions, such as fire alarms and fire-fighting equipment. However, some improvements were required. For example, two fire doors did not fully close when released, and some actions from a 2022 fire safety assessment were outstanding. The premises and fire safety are discussed further in the quality and safety section of the report.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This announced inspection was carried out as part of ongoing regulatory monitoring of the centre, and to help inform a decision following the provider's application to renew the registration of the centre. As part of their application, the provider has submitted a written statement of purpose on the matters outlined in Schedule 1, which the inspector was found to be up to date and readily available in the centre.

Overall, the inspector found that the management systems in place in the centre required improvement to ensure that the service provided to residents was consistent, safe, effectively monitored, and resourced in accordance with their needs.

There was a clearly defined management structure in the centre. The person in charge was full-time, and based in the centre to support their oversight of the care and support provided to residents. They reported to a Director, and there were effective arrangements for them to communicate with each other.

The registered provider had implemented management systems to monitor the

quality and safety of service provided to residents. Annual reviews and six-monthly reports, and a suite of local audits were carried out in the centre. However, the inspector found that the oversight systems were not fully effective, as they had not identified areas for improvement as found in this inspection, such as the failure to notify the Chief Inspector of Social Services of all adverse events in the centre. Furthermore, the inspector found that not all findings from previous inspections had been addressed.

The staff skill-mix consisted of social care workers. The person in charge was satisfied that it was appropriate to the assessed needs of the current residents. They were also complimentary of the care and support provided by the staff team, describing them as being very "experienced and diligent" in the duties. However, there were vacancies in the staff complement, filled by relief staff, which posed a risk to the continuity of care and support provided to resident.

Staff and the person in charge also told the inspector about how the vacancies were negatively impacting on them. For example, they were under increased pressure which affected their ability to carry out their duties.

Staff were required to complete a suite of training as part of their professional development, and the inspector found from reviewing the staff training log that their training requirements were up to date.

There were arrangements for the support and supervision of staff working in the centre, such as management presence and formal supervision meetings. Staff also attended team meetings which provided an opportunity for them to raise any concerns regarding the quality and safety of care provided to residents. Staff spoken with were satisfied that they could easily raise concerns with the person in charge. However, the inspector found that not all staff had received formal supervision in line with the provider's policy (the 2022 inspection of the centre had also identified this matter). The person in charge attributed the delay in the provision of formal supervision as a result of the staff vacancies which caused additional pressure for them and the staff team.

The inspector viewed the recent staff rotas, and found that they required improvement as they did not clearly show the names and hours working by all staff in the centre.

Regulation 15: Staffing

The staff skill-mix of social care workers was appropriate to the assessed needs of the residents in the centre.

However, there was one full-time vacancy in the centre that accounted for approximately 25 per cent of the total complement. Additionally, the person in charge told the inspector that there was another 0.3 whole-time equivalent vacancy, that was not reflected in the complement outlined in the statement of purpose. The

vacancies were filled by relief staff to support continuity of care for residents. The inspector viewed the May 2024 rota which showed that 13 overnight shifts were covered by four different relief staff. The person in charge and staff spoken with were complimentary of the relief staff. However, they said that the vacancies were having an adverse impact on the service provided to residents. For example:

- Some residents had expressed that they did not like relief staff working in the centre by removing their pictures from the visual rota.
- Relief staff did not drive the vehicle, which limited residents opportunities for community-based activities.
- One resident's behaviour support plan outlined that changes in the staff rota were a trigger for the resident.

The person in charge endeavoured to reduce the impact on residents by ensuring that a permanent staff member was always on duty.

Staff also told the inspector that the vacancies caused additional pressures, which was impacting on their ability to fulfil their duties and causing them stress. For example, some residents only liked permanent staff to assist them with their intimate care, and staff found it difficult to keep up with paperwork when working with relief staff. These concerns had also been raised by some staff during their supervision meetings with the person in charge.

The person in charge maintained planned and actual staff rotas. The inspector viewed the April and May 2024 rotas, and found that improvements were required to their maintenance and detail. For example, the full names of all staff working in the centre were not recorded on all dates in April 2024. Furthermore, a 'time sheet' (separate to the rotas) recorded that a relief staff worked in the centre on 28 May 2024. However, their name and the hours they worked were not recorded on the rota.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were required to complete a suite of training as part of their professional development and to support them in the delivery of appropriate care and support to residents. The training included safeguarding of residents, administration of medication, manual handling, first aid, hand hygiene, management of challenging behaviour, and fire safety. The training records viewed by the inspector showed that staff were up to date with their training requirements. Some staff had also completed training in additional areas, such as human rights, and the person in charge had recently completed a course on diversity and equality, to strengthen the quality of the service provided in the centre.

The person in charge provided informal support and formal supervision to staff.

However, the inspector viewed the supervision records for four staff, and found that the frequency of their supervision was not in line with the provider's policy. This posed a risk to their professional development. This matter had also been found during the 2022 inspection of the centre.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had effected a contract of insurance against injury to residents and other risks in the centre including property damage.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre. The person in charge was full-time and based in the centre. This was their sole centre of responsibility. They reported a reported to a Director of Social Care, who in turn reported to a Chief Executive Officer (CEO). The CEO had commenced in their role in March 2024, and had visited the centre to meet the residents. There were good arrangements for the local management team to communicate and escalate any concerns. For example, the person in charge attended weekly meetings with the Director.

The provider had implemented oversight and monitoring systems to assess the quality and safety of the care and support provided to residents, and to ensure that it was consistent. Annual reviews and six-monthly unannounced visit reports were carried out by the provider, along with a suite of audits on care plans, health and safety matters, incident notifications, safeguarding of residents, use of restrictive practices, infection prevention and control, and medicine administration and practices.

However, these systems required improvement to ensure that they were effective. The inspector found multiple areas for improvement during this inspection, that had not been self-identified by the provider, such as deficits in reporting incidents to the Chief Inspector. Furthermore, some of the issues had also been noted in previous inspection reports. For example, the 2023 inspection of the centre found deficits in the assessment of residents' communication needs. This did not demonstrate that inspection findings were being fully addressed by the provider to improve the quality and safety of the care provided to residents in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1. It had been recently updated, and was available in the centre to residents and their representatives.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed the adverse events and incidents, as specified under this regulation, notified to the Chief Inspector in the previous 12 months. The inspector found that the use of restrictive procedures had not been notified.

Judgment: Substantially compliant

Quality and safety

Residents did not communicate their views to the inspector. However, the inspector observed that they appeared to be relaxed in the centre, and read positive feedback from their representatives about the service provided to them.

However, the inspector found that improvements were required to aspects of the quality and safety of the service provided in the centre in relation to the premises, fire safety precautions, risk management, and the arrangements for ensuring that residents' communication and dietary needs were being met in the centre. The improvements were required to ensure that residents were in receipt of safe and quality care that ensured their optimum wellbeing and welfare in the centre.

Residents had complex communication means. However, the inspector found that not all residents had their communication needs assessed by an appropriate professional, or that care plans were in place for staff to follow to ensure that residents were supported to communicate in line with their assessed needs and wishes.

Arrangements, such as care plans and staff training, were in place to support residents with behaviours of concern. There was also a small amount of restrictive practices in the centre. Overall, the inspector found that the use of the restrictions

was in line with evidence-based practice. However, the provider's restrictive practice policy required enhancement to clearly describe arrangements for the oversight and approval of the use of restrictive practices from an organisational level.

The centre comprised the ground floor of a large two-storey building. Residents had their own bedrooms, and the communal space included a large hallway with seating furniture, a kitchen, and an open-plan dining and living room. Since the previous inspection of the centre in November 2023, parts of the premises had been upgraded. For example, flooring had been replaced in some bedrooms. The centre was observed to be clean, well-equipped, and generally well maintained. There was also different forms of media available to residents in the centre, such as televisions and the Internet. However, some maintenance was required to the premises, particularly to resolve the ongoing heating system issue.

The inspector observed that the kitchen was well equipped, and there was a good selection and variety of food and drinks for residents to choose. Residents were supported to make choices about their meals, and the inspector found that staff and the person in charge had good knowledge of their individual likes and dislikes. The inspector was told that one resident had a certain healthcare condition that required monitoring of their daily fluid intake. However, the inspector found that there was an absence of an up-to-date care plan, with input from a health professional, that detailed the exact support that the resident required. Furthermore, the recording of the resident's 'fluid intake' was inconsistent.

The fire safety systems had been enhanced since the previous inspection. For example, there was a new fire panel, and the lighting had been replaced. Regular fire drills were being carried out to test the effectiveness of the fire evacuation plans. Staff were familiar with the plans, and fire safety had been discussed with residents. However, improvements to fire safety systems, as recommended in a 2022 fire safety assessment, were outstanding, which posed a risk to their effectiveness.

There were arrangements to safeguard residents from abuse such as staff training in detecting, preventing and responding to safeguarding concerns.

The provider had prepared a risk management policy, which outlined how risks were identified, assessed and managed. The inspector viewed the centre's risk register, and found that improvements were required to the scope of the risk assessments and the development and maintenance of associate plan. For example, not all control measures as described by staff were recorded, and this posed a risk to the implementation of the measures.

Regulation 10: Communication

The provider had not ensured that all residents' communication needs had been assessed or that associated care plans, informed by relevant professionals, had been

prepared to guide staff on communicating with residents.

The previous inspection of the centre in November 2023, had also highlighted similar deficits, which had not been fully addressed.

All three residents living in the centre had complex and individual communication means. For example, some residents had limited verbal communication skills, and some residents repeated certain phrases to communicate. The inspector view the three residents' files and found that:

- Only one resident had a communication assessment and plan that was informed by a relevant professional. The plan was up to date and available to guide staff practices.
- One resident had a communication plan. However, it had been prepared by staff working in the centre, and did not reflect input from a relevant professional, such as a speech and language therapist.
- One resident's communication needs had not been assessed, and there was no communication plan in place.

The absence of communication assessments and plans (with input from relevant professionals) posed a risk to how effectively residents were supported to communicate their needs and wishes.

Judgment: Not compliant

Regulation 17: Premises

The centre comprised the ground floor of a two-storey building operated by the provider. The first floor was not used by the staff or residents in the centre, however it shared a main entrance way.

The premises of the centre comprised individual residents' bedrooms with en-suite facilities, staff rooms, an office, a utility room, a bathroom, a kitchen, and an open-plan dining and living room. There was also a long and wide hallway with seating furniture for residents to use.

The residents' bedrooms were spacious and had been decorated to their tastes. Since the previous inspection of the centre in November 2023, some upgrades to the premises had been carried out. For example, flooring had been replaced in bedrooms and the dining room, and the hallway had been repainted. Some further upkeep was required, as the inspector observed that the flooring in one bedroom was too high, which impeded on the door closing.

The centre was observed to be clean and well equipped. For example, residents had mobility equipment such as shower chairs. The inspector also observed that efforts had been made to make the premises more homely and accessible for resident. For example, photos of residents were displayed in the hallway, and there were board

games and musical instruments for residents to play. There were also large push buttons for residents to use to open the front door with ease.

However, there had been ongoing issues with the heating system, which had disrupted the operation of the centre. For example, in November 2023 and June 2024, there was a loss of heating, and residents were unable to stay in the centre. The provider had engaged their maintenance team to review the issues. However, the issue remained, and until it was fully mitigated, this posed a risk to residents' being able to reliably use the centre.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector observed a good selection and variety of food and drinks, including fresh food in the kitchen for residents to choose from. The kitchen was also well equipped with cooking appliances and equipment. Residents were supported to choose their menu on a weekly basis, but could change their minds if they wished to.

The residents did not cook independently, however were encouraged to choose their meals and help to prepare them. The inspector read information in residents' files on their favourite foods and preferences, to guide staff on preparing their meals and ensuring that foods they liked were available in the centre. Some residents also like to eat out and have occasional takeaways.

One resident required support regarding their daily intake of fluids. The inspector read an associated risk assessment which specified the daily fluid limit (''where possible''). Staff spoken with told the inspector that the 'limit' was to be reached. The person in charge also told the inspector about how much fluid should be taken at different periods during the day. However, the resident's general medical care plan did not specify the fluid amount. While there was an associated care plan with information on the fluid amount, the plan had last been reviewed in October 2022 and was not part of the resident's active file.

The inspector also found that the resident's fluid intake was not been consistently recorded. For example, the inspector reviewed the resident's fluid intake records from 27 May to 6 June 2024 and found gaps in the records on six of those days.

Overall, the inspector found that there was an absence of a cohesive care plan with oversight from a healthcare professional on the resident's needs. Furthermore, the gaps in the recording of the resident's fluid intake did not demonstrate that their support need was being monitored.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had ensured that a residents' guide was available to residents in the centre. The guide contained information on the services and facilities provided in the centre, visiting arrangements, complaints, accessing inspection reports, and residents' involvement in the running of the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had prepared a written risk management policy. The policy was dated September 2022, and it outlined the arrangements for the identification, assessment, and management of risks.

The inspector viewed the risk register related to the centre, and found that enhancements were required to ensure that the risk assessments reflected all relevant factors. For example, the fire safety risk assessment viewed by the inspector did not reference the issues outlined in the external fire safety assessment. The risk assessment relating to the impact of residents' behaviours also required more consideration in relation to the potential impact on other residents as described by staff to the inspector. The issues relating to staffing deficits had also not been adequately assessed.

The inspector also found that not all measures to reduce risks were documented. For example, staff gave the inspector a specific example of how they endeavoured to reduce the risk of residents being adversely impacted from the behaviours of other residents. However, that measure was not reflected in an associated plan, which posed a risk to the consistency of the implementation of the measure.

Staff also expressed concerns regarding how some incidents were being classed, and the inspector found that more consideration was required from the provider about this. The inspector discussed this with the Director before the inspection concluded, and was given verbal assurances that it would be addressed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had implemented good fire safety precautions in the centre. For example, there was fire detection and fighting equipment, and emergency

lighting, which was regularly serviced. Staff also carried out regular fire safety checks.

All of the residents' bedrooms had emergency exits that could be used to aid prompt evacuation of the centre. Individual fire evacuations plans had also been prepared to guide staff on evacuating residents. The effectiveness of the plans was tested during fire drills. The drills included night-time scenarios.

However, some improvements were required to ensure that the precautions were effective, and that audit findings were responded to in a timely manner.

The inspector also read a fire assessment of the premises, initially carried out in 2022 by an external party and reviewed again in 2023, which outlined the following outstanding areas for improvement related to the fire containment measures:

- 11 fire doors required certification, including the residents' bedroom doors.
- The gap between the six doors, including two bedroom doors, and their frames/floor was too wide posing a risk of potential smoke or fire entering.
- The intumescent seal around one bedroom door was damaged which compromised the effectiveness of the purpose of the door.
- Fours door did not close fully when released, including a resident's bedroom door and the kitchen door (the inspector released all of the doors during their walk-around of the centre, and found that two did not close fully, including the kitchen door). The inspector also found issues with the fire doors during the 2022 and 2023 inspection of the centre.

The inspector was told by the provider that they had received quotes for the required works, and were committed to undertaking them. However, they had not yet secured the required funding.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that supports were in place for residents with behaviours of concern. The inspector viewed one resident's behaviour support plan. The plan was up to date, readily available to guide staff practices, and had been prepared by an appropriate healthcare professional and in consultation with the resident's family. Staff spoken with told the inspector that the plan was mostly effective. Staff had also completed relevant training in this area to inform their practices.

There was a small number of restrictive practices used in the centre. The inspector reviewed the documentation related to one practice. The inspector found that the use of the practice had been subject to a risk assessment, had been discussed with the resident and their representatives, and its use was being recorded daily by staff.

There was information in the centre for staff to refer to on best practice regarding

restrictive practices. The provider had also prepared a written policy on restrictive practices. However, the inspector found that further detail was required in the policy on how restrictive practices were reviewed and approved at a provider level. The 2023 inspection of the centre had also identified this deficit in the policy.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that the registered provider had implemented systems to safeguard residents from abuse. For example, staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns, and there was guidance in the centre for them to easily refer to.

Intimate care plans had been prepared and outlined the individual supports residents required to ensure that staff delivered care in a manner that respected residents' dignity and bodily integrity. However, the inspector found that one plan required a small update to reflect changes in the resident's support needs.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Gentili OSV-0008149

Inspection ID: MON-0034996

Date of inspection: 06/06/2024

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: Although there is never a situation where a full-time member of the social care team is not present, the provider will ensure that the use of relief staff is minimised wherever possible. When relief staff are required, the provider will ensure that the Person in Charge (PIC) has reliable systems in place for explaining this requirement to the residents and for minimising any concern for residents that might arise in respect of this. This approach will require that all expected absences are communicated to the Director of Social Care in a timely way so that the residents will know as soon as possible why a staff change is happening, who will be providing cover and for how long. In addition, the provider will ensure, wherever practicable, that the centre will have a dedicated relief staff member, that is, someone who is known to the residents and with whom they are comfortable. In respect of unexpected absences these same steps will apply, albeit that they may have to be more constrained. In all cases, the PIC will be responsible for ensuring that appropriate communication strategies are utilised and that resident responses to the staff change are properly recorded and available to inform ongoing practice, particularly in terms of establishing continuity of care. Where continuity of care is at issue this will this will be discussed at team level and the PIC will provide the Director of Social Care with a written note of any specific concerns as these relate to individual residents. These concerns will also feed into the centre's risk register in order to ensure the provider remains focused on addressing this issue appropriately. In terms of the specific vacancy the provider will endeavour to fill this as soon as possible.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

Commencing early September, the PIC will ensure that a comprehensive, dated and timed supervision schedule is in place indicating a supervision frequency consistent with ChildVision's policy. The PIC will also ensure that supervision contracts are in place for each team member.

The supervision schedule will allow for variation due to staff members' occasional unavailability but only within the understanding that supervision frequency is not undermined, meaning that the PIC will prioritise rescheduling individual supervision as soon as practicable, adjusting the schedule to clearly indicate this. In addition an agreed supervision template will be in place to ensure that appropriate notes exist, thereby also helping provide consistency for individual supervisees. These notes will be available to the provider's representative to enable monitoring of agreed frequencies via the in-house six-monthly inspection process.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Audit processes, including but not limited to the in-house six monthly inspection processes, will be adjusted in line with the inspection finding in order to enhance their effectiveness in identifying anomalies, cross-referencing in-house compliance judgements with a higher degree of evidence, both documentary and observational. In addition, on an at least monthly basis the Director of Social Care (or designate) will attend the centre's team meeting, the intention being that this will help improve the capacity to correctly identify, among other things, matters that are notifiable to the Chief Inspector.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In addition to the improvements outlined in relation to regulation 23 the provider will ensure refresher training is provided specific to enhancing staff capacity (including relief staff capacity) to correctly identify and properly process restrictive practices.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
In respect of the resident identified as being without a communication plan, a plan was put in place immediately following the inspection and submitted to ChildVision's speech and language (SLT) department for input and sign-off. This young person has now transferred to another service outside ChildVision.

In respect of the resident whose existing communications plan was found not to have had input from a speech and language therapist this plan has now also been submitted to the SLT department for input and sign-off, once an assessment from SLT has been completed in early September once the young person returns to the service following their summer break.

All identified communication supports required by each resident will be reviewed monthly by the PIC to establish that they remain current and effective, with escalation to the SLT department if any concern arises. In addition, to underpin a cohesive approach on this, communication supports will become a standing item on the social care team's weekly meeting agenda, commencing the beginning of September 2024.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Extensive and on-going maintenance team work, supported by external contractors, is already – and has been – a feature of the provider's response to heating issues in the centre. This work will be redoubled until a viable solution is achieved.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition: Although the inspection findings here refer to a resident who has now left ChildVision's services the gaps in recording, identified in the inspection, will be addressed as a practice learning opportunity for the team. A review meeting will be organised with the team – this meeting to be attended by the Director of Social Care and the Clinical Nurse Manager – to establish why inconsistencies in recording happened, why the general medical care plan did not include the fluid amount and why the plan had not been reviewed more recently than October 2022. The serious defects identified by the inspector have potential implications for other current and prospective residents. The purpose of the all-team review will also be to identify and put in place robust audit and compliance arrangements to ensure errors of the type identified are better guarded against in the future.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The centre's risk register will be regularly reviewed by the provider – on at least a monthly basis - to ensure that it contains all risks identified as relevant to the centre, of whatever type, including any arising from specific behaviours. The provider will also ensure that a specific piece of mandatory training is put in place to better resource staff to identify risks and to properly classify and process them, including, if necessary, as reportable to the Chief Inspector. Generally, this training will be provided to support team members to use the centre's risk register as a proactive, 'living' document to enable better practice. In addition, risk is a standing item on the Director of Social Care's weekly meeting with all of ChildVision's PICs. Gentili's PIC will be encouraged to use this forum to discuss risks pertinent to the centre and to engage with the opportunities this forum presents to work through potential and actual risks collaboratively with the Director and fellow PICs. Further, the provider will ensure that responsibility for compiling and maintaining the centre's risk

register is a shared task across the entire team, thereby increasing the opportunity for team learning.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All fire doors will be certified by a competent professional and the gaps identified in respect of six doors will be remediated. The damaged intumescent seal will be replaced and door closure devices will be adjusted (or, if necessary, replaced) to ensure all doors are closing properly. In addition, as part of a weekly review one designated team member will test all of the doors to ensure that they continue to function properly and that the seals are in good order. The result of this weekly inspection will be recorded and any problems will be reported via email to the Director of Social Care and the maintenance manager as a matter for priority attention.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The restrictive practices policy will be reviewed to better ensure that it reflects how restrictive practices are reviewed and approved by the provider. This review will also include a piece crosslinking restrictive practices as a standing issue on the agenda of ChildVision's new Human Rights Committee, commencing in September 2024.	

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	06/09/2024
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	06/09/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less	Substantially Compliant	Yellow	30/09/2024

	than full-time basis.			
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.	Substantially Compliant	Yellow	03/09/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	13/09/2024
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	30/09/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2024
Regulation 18(2)(a)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	03/09/2024
Regulation 18(2)(d)	The person in charge shall ensure that each resident is	Substantially Compliant	Yellow	03/09/2024

	provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/09/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2024
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	30/03/2024

Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	02/09/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental	Substantially Compliant	Yellow	02/09/2024

	restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			