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:	Thornvilla Community Group Home
Name of provider:	North West Parents and Friends Association for Persons with Intellectual Disability
Address of centre:	Sligo
Type of inspection:	Announced
Date of inspection:	25 September 2023
Centre ID:	OSV-0001936
Fieldwork ID:	MON-0031913

About the designated centre

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

Thornvilla Community Group Home provides full-time residential care and support to adults with an intellectual disability. The centre can accommodate male and female residents over the age of 18 years.The centre comprises of a two-storey detached house set in its own grounds in a residential area of a town. The centre is in close proximity to a range of local amenities such as public transport, cafes, cinema and shops. Residents also have access to a vehicle at the centre to support them to access other activities and amenities in the surrounding area. In addition to their own bedrooms, residents living at the centre have access to community facilities which include a sitting room, kitchen and dining room. In addition, a large communal bathroom is available on each floor of the building. Residents are supported by a team of care assistants, with staff available during the day to support residents when they are not at their day service. At night-time, there are sleepover staff and waking night cover provided to support residents with their needs. In addition, the provider has arrangements in place to provide management support to staff outside of office hours and at weekends.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 25 September 2023	08:30hrs to 17:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection to monitor and review the arrangements that the provider had in place to ensure compliance with the Care and Support Regulations (2013) and to inform a registration renewal application. The inspection was completed over one day and during this time, the inspector met with residents, a family member, and spoke with staff. In addition to discussions held, the inspector observed the daily interactions and the lived experiences of the resident in this designated centre. From what the inspector observed, it was clear that the residents were enjoying a good quality of life and were involved in their community. However, improvements were required with staffing levels and the provision of staff supervision, residents' personal plans, positive behaviour support, risk management arrangements and the overall governance and management systems to ensure that the care and support provided was of a good quality and ensured that people were safe.

This centre had experienced changes since the last inspection. In July 2022, an NF30 notification was submitted as the provider had recruited a new chief executive officer (CEO) who had a number of roles in the organisation. These included as person participating in management (PPIM) for the provider and as person in charge (PIC) for this designated centre and for another located close by.

Thornvilla is a two-story detached house set on its own grounds close to a busy town. Since the last inspection, the property had maintenance work completed. This included fresh paint, new floor coverings and a new kitchen was fitted. In addition, the laundry machines were removed from the dining room to a building at the back of the garden. This was used by the residents for the laundering of linen and clothing. The use of this room will be expanded on under regulation 3 below. Residents had their own bedrooms which were comfortable and personally decorated. Communal bathroom facilities were located on both floors. At the rear of the property there was a spacious garden where residents had tomato plants and cheerful flower pots.

In advance of the inspection, residents had completed questionnaires with the support of staff. Feedback from the residents showed that they were happy in their home and with the quality of the care and support provided.

On arrival, the inspector met with the person in charge and two staff members. The residents were observed preparing for their day. Three residents were driven to their day service by a staff member on duty. Two residents remained at home which was their preference. They were observed rising from sleep and preparing for breakfast. They held brief conversations with the inspector and said that they were happy in their home. Interactions between residents and staff were kind, caring and respectful.

Contact with residents' families was facilitated and supported by the staff team. This

included telephone calls and visits home if appropriate. In addition, residents' family members visited the centre in accordance with the residents' wishes. This was observed on the afternoon of inspection when a family member visited. They told the inspector that they were very happy with the service provided and that the staff were very supportive. In addition, they said that they always felt welcome when they called to visit and that it was a happy home.

The inspector met with two staff members on the day of inspection. When asked, they spoke with the inspector about using a human rights approach to their work. They said that they completed training modules in human rights and the information gained acted as a reminder of the importance of using a person centred rights based approach in their work. They spoke about offering choice, positive risk taking and advocating for rights on a daily basis.

From what the inspector observed during the inspection, it was clear that the residents were provided with a good level of care and support. The staff on duty were very familiar with the residents and adapted to provide for changes in residents support needs if required. Interactions with residents were found to be caring and respectful. However, the inspector found that the governance and management systems in place required review. This will be expanded on in the next two sections of this report which presents 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 provided.

Capacity and capability

The inspector found that although there was a defined management structure in place and clear lines of authority, the monitoring and oversight systems required improvement. The inspector met with the person in charge on the day of inspection and found that they had the qualifications, skills and experience necessary to fulfil their role. However, they held a number of other roles for the provider. Although they were available to provide support to the staff team as required, they were not always present in the designated centre. This impacted on the operational administration of the centre.

The provider had a range of policies and procedures available in the centre. A review of those available found that improvements in relation to duplication of documents and due dates was required. These matters were amended on the day of inspection.

In addition, the provider had a statement of purpose which was available to read. This was reviewed on the day of inspection and amendments were made by the person in charge. However, the inspector found that an additional laundry room was provided since the last inspection. It was not reflected on the plans for the centre. This was not in line with the requirements of the Schedule 1 of the regulations and

an application to vary the registration conditions is required.

A review of the documentation systems showed that significant improvements were required. For example, some documents were out of date and therefore not relevant to the resident or the service. However, they remained on the files viewed and this impacted on the delivery of clear guidance. In addition, although there was an audit schedule in place it was not effective. For example, the annual review of care and support had no actions planned. The twice per year provider-led audit was completed by the person in charge and therefore may not be objective. Furthermore, audits on risk management, safeguarding and positive behaviour support were not identifying gaps in the service. This required review.

The inspector met with staff members on the day of inspection. They spoke about the improvements to the house since the previous inspection. They told the inspector that they enjoyed their work. In addition, they said that the person in charge was supportive and readily available if required. However, they said that the service was experiencing challenges in relation to staffing levels and they worked additional hours to ensure that the residents' needs were met. A review of the staffing arrangements found a planned and actual roster which provided an accurate account of the staff present at the time of inspection. The number and skill mix of staff provided met with the assessed needs of residents. Agency staff were used. They were reported to be consistent and familiar with the assessed needs of residents. An on-call system was used, which staff said worked well. However, the inspector found that the four staff members had left the service recently and the daytime shift was removed. In addition, staff had additional responsibilities in relation to the transportation of residents to and from their day service and the attendance at medical appointments. This meant that they were working additional hours. This was not sustainable as it could impact on the consistency of the care and support provided.

Staff had access to appropriate training, including refresher training, as part of a continuous professional development programme. A staff training folder was maintained which included details of when staff had attended training. In addition to mandatory training, additional training was provided if required. For example, staff were due to attend training in augmented sign language in order to support a resident with hearing loss. All training modules from the sample reviewed were up to date. A formal schedule of staff supervision and performance management was in place. However, meetings had not taken place in accordance with the provider's policy.

As outlined at the outset, this inspection was completed in order to monitor compliance and to inform a registration renewal application. The provider submitted a full application which complied with the requirements of Schedule 1 of the registration regulation. A contract of insurance was in place.

In summary, although there was a defined management structure in place and a dedicated staff team, the systems in place to monitor the quality and safety of care provided to the residents were not effective. Improvements in the governance and management systems in place were required. The next section of this report will

describe the care and support people receive and if it was of good quality and ensured people were safe.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a full application which complied with the requirements of Schedule 1 of the registration regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a person in charge who worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. However the following required review;

- to ensure that there is effective governance, administration and operational management of the designated centre where the person in charge has additional roles.

Judgment: Substantially compliant

Regulation 15: Staffing

This service was experiencing challenges in relation to the provision of staff. The person in charge told the inspector that a recruitment campaign was ongoing. The inspector found that the provider had an appropriate number and skill-mix of staff on duty. The roster provided an accurate reflection of the staff on duty on the day of inspection. An on-call system was in place and consistency of care and support was provider. However, the arrangements in place required review in relation to the following;

- The daytime shift was discontinued. This meant that in order to meet with the residents' assessed needs, staff were required to work additional hours. For example, to attend medical appointments with residents. In addition, the staff on duty had an additional responsibility added to their role which included transporting residents to and from the day service.
- A review of the rosters found that one staff member was on the roster twelve days in a row. This included seven sleepover shifts. A second staff member was on the roster nine days in a row. This included five sleepover shifts. This was not sustainable and impacted on the ability to provide consistency of

care and support.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to training, including refresher training, as part of a continuous professional development programme. The sample reviewed found that mandatory training modules were up to date. However, the following required improvement;

- The provider had arrangements in place in relation to formal supervisory support for staff. However, supervision meetings were not provided.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had a contract of insurance in place that met with the requirements of the regulation.

Judgment: Compliant

Regulation 23: Governance and management

The governance, management and oversight systems in place failed to ensure that the service provided was safe, appropriate to the residents needs and effectively monitored.

- The person in charge had additional oversight of a range of services on behalf of the provider which impacted on the operational management of the centre.
- The arrangements in place to monitor information held at the centre required review to ensure that all information was up to date and that old information was removed from residents' files.
- The annual review of the quality of care and support was completed in August 2023. However, there was no action plan to address areas for improvement.
- The six monthly provider-led audit was completed in August 2023. However, this was not an un-announced audit as it was completed by the person in charge.

- The quality improvement planning process was linked to the six monthly provider-led audit. These audits did not show consistent monitoring of all actions identified
- Service level audits that were in place were not always relevant or effective
- Risks in relation to safeguarding and positive behaviour support were not assessed or addressed
- Safeguarding notifications were not submitted to the Chief Inspector.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which did not meet with the requirements of Schedule 1 of the regulations.

- An application to vary condition 1 of the registration conditions was required as the floor plans were not an accurate reflection of the property provided.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the documentation found that notifications were not reported to the Chief Inspector of Social Services in a timely fashion and in line with the requirements of the regulation. For example;

- notifications in relation to a safeguarding incidents were not submitted as required.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Written policies and procedures were prepared in writing and available in the centre. Those reviewed were up to date and in line with the requirements of Schedule 5 of the regulation.

Judgment: Compliant

Quality and safety

The inspector found that the care and support provided in Thornvilla was good quality. It was provided by a dedicated staff team and environment provided met with the residents assessed needs. However, improvements were required in relation to the statement of purpose, staffing levels, the provision of staff supervision, residents' personal plans, positive behaviour support, risk management arrangements and the overall governance and management systems in the centre.

Residents had assessments of their health, personal and social needs which were available to read. A keyworker system was used and residents and their representative were involved in planning meetings. Activities included gym sessions, theatre and cinema trips, visiting the life boat station and going out for dinner. However, the inspector found inconsistent information on residents' files. For example, one resident had two action plans. One which was a repeat of the actions from the previous year and another which was four years old and required removal. Another plan related to goals set in a day service which were not relevant to the resident's home.

Residents who required support with their health and wellbeing had this facilitated. Access to a general practitioner (GP) was provided along with the support of allied health professionals in accordance with individual needs. For example, residents attended speech and language therapy. In addition, residents had access to consultant based services if required. Another resident with a specific medical condition attended a monitoring clinic.

Some residents in this designated centre required support with behaviours that were challenging. Positive behaviour support plans were in place. However, the support of a specialist in behaviour management was not provided. The inspector was not assured that the behaviour support strategies were consistently used and effective. In addition, a consultant recommended a referral to the support of a psychologist. However, there was no evidence to show that this was progressed. Furthermore, restrictive practices were in place in this centre. However, not all restrictions were acknowledged and documented. For example, male residents were not allowed use the downstairs toilet.

The provider had some arrangements in place to ensure that residents were protected from abuse. A safeguarding and protection policy was in place and staff were provided with training which was up to date. Staff were aware of the identity of the designated officer. However, a review of documentation found that not all safeguarding issues were acknowledged as such and there was a failure to act on occasions when there may be grounds for concern.

The provider had some management systems in place for the assessment, management and ongoing review of risk. However, improvements were required in relation to documents held which were not always easily accessible and did not always provide a clear guidance. In addition, residents' individual risk screening

tools and individual risk assessments required review to ensure that they were up to date and in line with current recommendations.

The provider had arrangements in place to reduce the risk of fire in the designated centre. These included arrangements to detect, contain, extinguish and evacuate the premises should a fire occur. The fire register was reviewed and the inspector found that fire drills were taking place on a regular basis. Residents had personal emergency evacuation plans and all staff had completed fire training.

The provider had arrangements in place for the ordering, receipt, storage and administration of medicines. Medicine records were stored in a safe and accessible place. Medicines were stored securely.

In summary, residents at this designated centre were provided with a good level of care and support by a dedicated staff team. However, the person in charge had numerous responsibilities and this impacted on their oversight of this designated centre. Improvements were required with staffing levels and the provision of staff supervision, residents' personal plans, positive behaviour support, risk management arrangements and the overall governance and management systems to further enhance the care and support provided and to ensure that people were safe.

Regulation 26: Risk management procedures

The provider had some systems in place for the assessment and management of risk, however, the following required improvement;

- The documents in relation to health and safety in the centre required review to ensure that the information provided was easy to access and provided a clear message in relation to health and safety.
- Residents' individual risk screening tools required review to ensure that they were up to date. For example, a risk screening form used was dated 2010.
- Residents' individual risk assessments required review to ensure that they were up to date. For example, risk assessments in relation to road safety, skin conditions and COVID-19 did not provide up to date information.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had fire safety management systems in place including arrangements to detect, contain and extinguish fires and to evacuate the premises.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had arrangements in place for the ordering, receipt, storage and administration of medicines. Medicine records were stored in a safe and accessible place. Medicines were stored securely.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents were found to have assessments completed of their health, personal and social needs and a keyworker support system was in place. Evidence of the participation of family representatives in the process was provided. However, the following required improvement;

- To ensure that person plans provided are clear and concise.
- To ensure that plans are reviewed regularly to access the effectiveness of the plan

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health and wellbeing. Where health care support was recommended and required, residents were facilitated to attend appointments in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector was not assured that the systems in place to support residents with behaviours of concern were effective. Improvements were required as follows;

- Although residents requiring support with behaviours of concern had plans in place, the support of a specialist in behaviour support was not provided.

- Evidence of the completion of behaviour support strategies as recommended by the support plan was not always provided.
- A written recommendation to refer a resident to a psychologist was made by the metal health and intellectual disability team. Evidence was not available to show that this was progressed.
- Restrictive practices were in place in this centre. However, not all restrictions were acknowledged and documented. For example, that male residents were not allowed to use the downstairs toilet.

Judgment: Not compliant

Regulation 8: Protection

The provider had not ensured that residents were protected from abuse.

- Safeguarding and protection concerns were not acknowledged as such. For example, a review of behaviour management records found that a resident became upset and tearful on occasion due to the behaviour of their peer. The providers failed to take action when there may have been grounds for concern.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Thornvilla Community Group Home OSV-0001936

Inspection ID: MON-0031913

Date of inspection: 25/09/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • An advertisement for the position of 'Person In Charge' was published on 18th September 2023 and closed on 2nd October 2023.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The 'Day Time' shift has been reinstated, effective 9th October 2023 – this will improve the flexibility within the staff pool. • Efforts to recruit additional staff are ongoing - Interviews for additional staffing have been completed (w/c 25.09.23) and an additional staff member appointed, due to commence Monday 23rd October 2023. This will reduce the number of hours 'in excess of contract' requiring to be covered by staff. • Further staff interviews were held on Thursday 12th October 2023 with an additional staff member appointed – commencement date subject to Garda Vetting.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Staff Supervision Policy (HR051_04) will be fully implemented with immediate effect • Effective staff supervision will be established within the service with immediate effect	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

• A dedicated PIC will be in place after transition to the HSE. The advertisement of the position of PIC closed on 2nd October 2023 • A detailed review of all hard copy folders and Service User files is to be undertaken with the objective of reducing documentation held and ensuring that information is relevant, current and correct with immediate effect • The next Team meeting in Thorn Villa is scheduled for Tuesday 24th October 2023. The HIQA Report will be reviewed in detail with all staff and issues for action as identified will be addressed. This will include: o key actions to be included in the Annual Report o Conformance to HIQA requirements o A review of audit processes in the context of the Quality Assurance Cycle o Accessing specialist advice/support as necessary (eg Positive Behavioural Support)

Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • Floor Plan for Knappabeg Club has been provided • Statement of Purpose has been revised to include Knappabeg Club (used for Thorn Villa washing machine) • Application to vary submitted 18th October 2023	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • All notifications of incidents will be submitted to the Chief Inspector in line the requirements of Regulation 31 with immediate effect	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • A detailed review of all hard copy folders and Service User files is to be undertaken with the objective of reducing documentation held and ensuring that information is current and correct w/c 23rd October 2023 • Documentation exceeding a 12 month period will be removed/archived (unless directly relevant to current interventions) w/c 23rd October 2023 • Policy IH061_05 'Risk Management and Emergency Planning policy and procedures' to be re-issued to all staff w/c 23rd October 2023 • All Service User Risk Assessments to be reviewed/revised as necessary by 31st October 2023	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:	

• Key Workers are required to undertake a complete review of each Service User's personal plan for care and support by 31st October 2023 • A detailed review of all hard copy folders and Service User files is to be undertaken with the objective of ensuring that information is relevant, current and correct w/c 23rd October 2023 • Documentation exceeding a 12 month period will be removed/archived (unless directly relevant to current interventions) w/c 23rd October 2023

Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Service User referral to Psychology Services (as requested by Consultant Psychiatrist) made on 31st October 2023 • Policy IH089_05 'The implementation of positive behaviour support and use of restrictive practices' to be re-issued to all staff w/c 23rd October 2023 • Referral process for professional support to be outlined at next team meeting in Thorn Villa (scheduled for Tuesday 24th October 2023) • All staff will be required to undertake training 'Changes to the Rules and Code of Practice on Restrictive Practice' (MHC, 2023) on HSELand.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • Policy IH049_05 'Safeguarding vulnerable adults at risk of abuse' to be re-issued to all staff w/c 23rd October 2023 • All Service User Risk Assessments will be reviewed/revised by 31st October 2023	

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	31/12/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/11/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately	Substantially Compliant	Yellow	30/11/2023

	supervised.			
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	31/10/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/10/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	13/10/2023
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of	Not Compliant	Orange	31/10/2023

	abuse of any resident.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	31/10/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/10/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Not Compliant	Orange	31/10/2023

	to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	24/10/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	24/10/2023