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:	DC5
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	14 October 2022
Centre ID:	OSV-0003642
Fieldwork ID:	MON-0034798

About the designated centre

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

St John of God, Designated Centre 5 is a designated centre located within a campus setting in County Kildare. The centre provides residential services to 13 adults with an intellectual disability. The centre is a purpose built building which consists of three kitchens, four dining rooms, four sitting rooms, staff office, two sensory rooms and 13 individual resident bedrooms. The centre is located close to a town with access to local shops and transport links. The centre is staffed by a person in charge, clinical nurse manager, staff nurses, social care workers and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Friday 14 October 2022	11:00hrs to 17:15hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

St. John of God, Designated Centre 5, is a centre located within a campus setting in County Kildare. The centre currently provides residential services to a maximum capacity of 13 adults with an intellectual disability. At the time of the inspection, ten residents were living in the centre. The centre is a purpose-built single-storey building which consists of three kitchens, four dining rooms, four sitting rooms, two sensory rooms and 13 individual resident bedrooms. The centre is further divided into four houses, with residents residing in various areas of the centre in accordance with their needs. For instance, four residents shared one house, while in another house, one resident lived alone. This demonstrated that the centre could accommodate the demands of residents who desired to live alone or required a reduced-stimulation environment.

The inspector greeted all residents that lived in the centre and were present during the course of the inspection. Most of the residents the inspector met and greeted during the inspection were unable to verbally communicate their feedback about the service. One resident had expressed to staff that they wished to meet the inspector and were happy for the inspector to sit with them while they were having tea.

Residents living in this designated centre required considerable supports in relation to their manual handling and healthcare needs. To accommodate residents' mobility and manual handling needs, the provider ensured the centre was equipped with a wide range of manual handling aids and equipment. Bathrooms were supplied and fitted with various assistive aids, and overhead tracking hoists were also available. Residents were also provided with aids and appliances that supported their personal hygiene and intimate care needs.

Staff spoken with advised the inspector on how residents were supported with their meals and menu choices. The residents were supported to shop in the local grocery shops and planned the weekly menu at residents' meetings. The residents' main meals came from a central kitchen on campus. However, there were options to choose from and alternative foods and snacks in the centre. The inspector found that staff advocated on residents' behalf relating to meal choices, quality and variety. Suggestions made by staff regarding the mealtime experience for residents had been escalated through the person in charge to the catering department, and changes were made on the back of these recommendations.

Residents were found to be supported to take part in meaningful activities based on their interests, and each resident had a meaningful day timetable in place. Six residents attend day service programmes in another building on campus, while four residents are supported with day activation from the centre. The inspector found the residents' rights to engage in activities of their choosing were promoted in the centre. There were detailed activity records kept in residents' files along with photographs and wall notices regarding activities available and completed by residents. Some activities the residents had recently taken part in were a holiday to

Cork, a trip to Powerscourt Waterfalls, visiting a donkey sanctuary, a local music festival, music sessions, baking, massage and aromatherapy. Two residents had taken part in a 'Run and Roll' 5km walk supported by staff for wheelchair users and non-wheelchair users. Their achievements were highlighted in a picture frame that proudly displayed their photographs and medals. A picture was displayed in the centre of some residents being involved in the exterior painting of the centre and providing refreshments to the group of volunteers painting. It was documented that some residents had attended the retirement party of a staff member.

The inspector spent time with one resident who they had met previously when they were living in another designated centre. At first, the resident sounded upset at some of the construction work ongoing in the centre. However, they quickly returned to engaging in conversation with staff and the inspector, and the noise did not appear to disturb the resident. It was clear that the resident knew the maintenance staff who worked in the centre and that they were aware of the reasons why work was being performed. The resident informed the inspector that they had gone costume shopping for a Halloween party, displayed their outfit, and expressed excitement about going to the event.

The inspector spoke with some members of staff during the inspection. It was evident that staff members had a good level of knowledge of the measures required to support residents to meet their needs and to manage risk in the centre. Supports were observed being provided by staff members in a kind and respectful manner. Staff spoke about residents in a professional manner, and were very knowledgeable on the residents' needs and associated supports. Staff described the quality and safety of care provided to residents as being very high. The inspector observed staff engaging with residents throughout the inspection. The interactions between staff and residents were warm and kind, and residents appeared relaxed and content in the company of staff.

Overall, the inspector found areas of improvement regarding premises and infection control from the previous inspection in January 2022. The inspector found that each resident’s well-being and welfare was maintained to a good standard. However, the inspector found that further improvements were required to the premises, infection prevention and control measures, fire safety systems and staff training.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

The purpose of this inspection was to follow up on the provider's progress to findings from the previous inspection in the centre from January 2022. That inspection focused solely on infection, prevention and control and regulation 27. This inspection demonstrated the provider had made progress in addressing areas of

concern from the previous inspection and had increased oversight of maintenance issues and housekeeping procedures within the designated centre. This matter is further discussed under the quality and safety regulations. Under the capacity and capability regulations improvement was identified in the frequency of staff supervision sessions, however this had already been self-identified by the provider and actioned.

Clearly defined management structures identified the lines of authority and accountability within the centre. Staff reported directly to the person in charge, a clinical nurse manager (CNM2) based within the centre. The staff team consisted of a CNM1, staff, nurses, social care workers and healthcare assistants. Since the previous inspection, a new person in charge had been appointed in January 2022, strengthening the governance structure in the centre, as the centre had been without a full-time person in charge since January 2021. The CNM3, who holds responsibility for a number of areas, held this position until a full-time person in charge who met the requirements of the regulations could be recruited. The person in charge was very familiar with the residents' assessed needs and it was evident during the inspection that they had regular contact with all the residents.

There were arrangements in place to monitor the quality of care and support in the centre. The person in charge and CNM3 carried out various review audits in the centre on key areas related to the quality and safety of care provided to residents. Audits included infection prevention and control, medicines management, finances and personal plans. The audits demonstrated good practice in the various areas of quality and safety and also highlighted areas for improvement. For instance, the inspector saw that the person in charge did thorough evaluations of personal plans. Where information was missing or due for review, the actions were clearly assigned to the relevant keyworkers. The person in charge indicated that they met with each key worker individually to discuss the actions and set up follow-up meetings to review the work completed.

The provider had also ensured that an unannounced visit to the centre was completed as per the regulations. The inspector noted the six-month unannounced audit from August 2022 was comprehensive in scope and effective at reviewing the service being provided to residents in line with regulations, standards and provider policies. This process was monitored using a quality enhancement plan (QEP). The QEP allowed for managerial tracking of actions arising from previous inspections, six-month unannounced audits and internal audits.

Staff meetings were held regularly in the centre, and records indicated that a variety of topics were addressed. These included residents' activities, infection prevention and control, training, accidents and incidents, risk management policy and fire safety systems. The inspector also observed knowledge sharing with day services through meetings held between managers of both services, discussing goal-setting, positive behavioural support and medicine protocols. By ensuring that day services staff had access to the most recent information regarding residents, this further demonstrated continuity of care to residents while they were away from the centre.

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, fire safety, infection control and manual handling. The person in charge maintained a register of what training was completed and what was due. As stated in the six-month unannounced visit in August 2022 on review of staff training, there had been significant improvement made since the previous visit. While some training was required, the person in charge had dates booked for staff to attend the majority of relevant training. Furthermore, since August, the inspector found all staff were now in receipt of refresher training in safeguarding and dysphagia. Improvement was still required in managing behaviours of concern.

The person in charge provided informal and formal supervision to staff in the centre. Informal supervision took place daily, and formal supervision was scheduled to occur four times a year. All staff had received one formal supervision session with a second session scheduled. The quality and safety adviser had self-identified through the six-month unannounced audit that adjustments needed to be made to the supervision frequency to ensure it was in line with the provider's policy. The inspector observed that this action and other recommendations made by the quality and safety advisor had been inputted into the centre's QEP for monitoring purposes.

Regulation 14: Persons in charge

A new person in charge was appointed to the role in January 2022. They were a suitably qualified and experienced person in charge that met the requirements of Regulation 14 in relation to management experience and qualifications. They were engaged in the governance, operational management and administration of the centre and were present in the centre on a regular and consistent basis.

Judgment: Compliant

Regulation 15: Staffing

The person in charge had ensured that there was both a planned and actual roster maintained. From a review of the roster, it was evident that there was an appropriate skill-mix of staff employed at the centre.

The person in charge maintained a planned and actual roster. From a review of the staff roster, the inspector found that on the day of the inspection, staffing levels at the designated centre were appropriate to meet the needs of the residents. The centre's total whole-time equivalent (WTE) was 31.86, and on the day of the inspection, there was an 0.5 WTE nursing vacancy and two vacancies due to statutory leave. The inspector found that the continuity of care and support to

residents was being maintained through the use of a small pool of relief staff known to residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre had access to appropriate training as part of their continuous professional development, and to support them in delivering good care to residents. The person in charge maintained staff training records. Some staff were found to require training in positive behaviour support, which is actioned under regulation 7 Positive behavioural support.

Formal staff supervision was occurring in the centre, it had been identified in the providers own audits that improvement was required to ensure it was being completed as per the schedule.

Judgment: Substantially compliant

Regulation 23: Governance and management

A clear governance and management structure was in place at the centre. A full-time, competent, and experienced person in charge managed the centre. The person in charge had a solid knowledge of the residents and their particular support requirements. A number of quality assurance audits were also conducted to evaluate how care and support were provided in the centre. These included the six-monthly unannounced provider visits and audits carried out by the person in charge and others. Action plans were created in response to the audits' identification of areas that needed improvement.

In addition, there was an annual review of the quality and safety of care available in the centre for 2021, along with six-monthly auditing reports/unannounced visits. The annual review included feedback from residents and families, and it effectively addressed the quality and safety of care and support in accordance with relevant national standards.

Staff had access to the support of the management team should they have any concerns relating to residents care and support in the centre and members of the management team met with were committed to ensuring a quality and safe service was delivered to residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of incidents and accidents occurring in the designated centre and found that they were appropriately notified to the Chief Inspector as required by Regulation 31.

Judgment: Compliant

Quality and safety

The inspector found that there was a governance and management structure with systems in place which aimed to promote a safe and person-centred service for residents. The provider had addressed a number of actions from the previous inspection. A number of actions were still in progress at the time of the inspection, as discussed under regulation 27 and regulation 17. The inspector also found that improvements were required to the fire safety system and positive behavioural support.

The inspector completed a walk-through of the premises accompanied by the person in charge. The centre had undergone many premises upgrades since the previous inspection in January 2021. In addition to the rooms mentioned in the report's opening section, there were numerous additional rooms, including 25 bathrooms, ten store rooms, nine offices, three clinical rooms, two laundry rooms, two linen rooms, and one archive room. Prior to the successful decongregation of residents into smaller community-based homes, the centre accommodated a larger number of residents. Many areas of the centre were unoccupied or used infrequently and were not included in the housekeeping schedule for cleaning. As a result, the previous inspection, which focused on regulation 27: Protection against infection, was found non-compliant. An immediate action was issued in which the provider responded with their commitment to undertake a deep cleaning of the centre and address areas of concern.

The inspector found a deep clean had occurred and a review of the housekeeping duties and hours had taken place. Additional hours had been allocated on a daily basis for the upkeep of the centre's cleanliness. Whereby housekeeping staff had worked in the centre until 12.30pm, this had been increased to 3.30/4.30pm. The inspector observed the centre to have higher standards of cleanliness, and unused rooms had been reorganised to provide better storage. Walls had been refilled and painted both internally and externally, new floors laid, bathrooms reconfigured and new ceiling hoists installed. Residents had access to increased communal space with a newly devised music room that was brightly painted and had several musical instruments, mirrors and a projector screen. While progress had been made to the premises since the previous inspection, there remained a number of outstanding

works required to improve the premises. These included the replacement of radiators, new furniture, replacement of kitchen presses, completion of bathrooms and laundry room and shelving units to be installed. However, from reviewing the centre's quality improvement plan (QEP) and the provider's last six-month unannounced audit of the centre in August 2022, all these actions had been self-identified and actioned with a time-bound plan for completion.

The provider was currently reviewing the fire safety measures in all of its designated centres, in particular fire containment measures. On the day of the inspection, the inspector observed fire doors being fitted and installed in one part of the designated centre. A number of actions arising from the six-month unannounced audit had been completed, including the replacement of faulty fire doors and improved documentation of fire safety plans. For instance, the site-specific emergency plan for the centre was modified to reflect the number of residents, the number of bedrooms, and the centre's specific evacuation protocols. The plan was further developed to include details on compartmental evacuation, the procedures required, and the rationale. From speaking with staff, they demonstrated a good understanding of the fire evacuation procedures and confirmed they had participated in fire drills within the centre.

Residents' healthcare needs were met to a good standard. Residents received annual health checks with their General Practitioner (GP) and additional allied health professional assessments and reviews as required and relevant to their age profile. Healthcare planning for conditions such as diabetes, epilepsy, and skin integrity were of a good standard and were kept up-to-date and reviewed to reflect changes in residents' health profiles. In addition, where residents required other healthcare supports, they were supported to attend their outpatient appointments on a regular basis.

The provider and person in charge promoted a positive approach in responding to behaviours of concern. Overall, there were systems in place to ensure that where behavioural support practices were being used that they were documented and reviewed by the appropriate professionals on a regular basis. However, as previously mentioned, not all staff had the required refresher training in positive behavioural support. The inspector reviewed a sample of positive behaviour support plans, and they contained proactive and reactive strategies to guide staff on how best to support the resident. On speaking with staff members, the inspector found that they were very familiar with residents' needs and the various supports in place to meet those needs. The inspector saw that where restrictive procedures were being used, they were based on centre and national policies, and staff took the least restrictive approach. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual.

The inspector found many examples of good monitoring of the behavioural support needs of residents. A clear tracker was in place and maintained by the person in charge that identified the level of positive behavioural support each resident required, the restrictive practice applied to any residents, the plan date and dates

for review. Improvement was required at the provider level to ensure the relevant committees for oversight of restrictive practices were operating as designed.

The provider had systems in place to manage and control risks in the centre. There was effective management of risk in the centre, with evidence of staff implementing the provider's risk management policies and procedures. There was a risk management policy in place which reflected the requirements of the regulations. For example, specific risks as outlined in the regulation such as aggression and abuse, and associated measures and actions to control these risks were included. The risk policy also outlined procedures for the management and reporting of non-serious and serious incidents at the centre. There was evidence that staff had read and signed the reviewed risk register, with 18 staff members having signed the register at the time of the inspection. The provider had arrangements in place to identify, record, investigate, and learn from adverse incidents. Incident reports were reviewed in staff meetings and sent to members of the multi-discpinary team for review and recommendations. Examples included updating residents healthcare plans for signs of pain or infection.

Regulation 13: General welfare and development

The person in charge ensured that each resident had appropriate care and support to access activities of their choice. This included attending day services on a reduced schedule as per individual wishes. Residents also had many opportunities to participate in a variety of community-based activities in line with their interests, preferences and personal goals. The centre had the sole use of two buses to facilitate community activities. A review of records found that residents socialised in their local community, attended day services, visited family members and friends and had visits to their home.

Judgment: Compliant

Regulation 17: Premises

Overall, efforts had been made to make the premises homely, with the provider seeking to address maintenance issues that had been identified on audit and through the maintenance log. Accessibility arrangements in place for residents as required in relation to ramps, assistance aids and mobility equipment.

Each resident had their own private bedroom which had been decorated to reflect their individual likes and interests. Residents were observed using their bedrooms for rest and relaxation purposes during the course of the inspection.

While improvements had been made since the previous inspection, several actions within the centre's QEP still required completion. The date given within the QEP for all outstanding premises works was December 2022.

These included:

- Replacement of kitchen cabinets
- Store rooms to be fitted with storage options and shelving
- Reconfiguration of unused bathrooms
- Painting of some internal walls
- New furniture required in some parts of the centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register that detailed centre-specific risks and the measures in place to mitigate the identified risks. In addition, individualised risk assessments were in place for identified risks, including behaviour, falls and manual handling.

Risk management plans outlined the control measures in place to mitigate against identified risks and plans were regularly reviewed. The inspector found control measures as outlined in plans were implemented in practice, for example, positive behaviour support measures for residents, assistive equipment to prevent falls, infection control measures and healthcare interventions in response to an identified healthcare risk.

There was a system in place in response to adverse incidents including reporting and recording incidents, a review by the person in charge post incidents, and ensuring that any required follow up interventions were completed.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had improved systems in place for the prevention, control and risks of infection since the previous inspection. In addition, there was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents if required.

The provider had assessed regulation 27: Protection against infection, on each of their six-monthly unannnounced visits to the centre. Detailed infection, prevention

and control audits had been completed with actions identified. The inspector found improved oversight of the water testing system for legionella disease and other harmful bacteria. Staff carried out twice weekly flushing of all taps and outlets in the centre and a record of this was maintained. Other water checks were routinely carried out, including water temperatures and sampling. While some water temperatures were recorded outside of normal limits, post-inspection follow-up indicated the matter was investigated with a replacement pump ordered and installed to address the problem.

As per regulation 17, some issues were outstanding on the centres QEP that could impact infection prevention and control including the following:

- Significant amount of dust on radiators throughout the designated centre
- Exposed pipeworks in one bathroom required addressing
- New tiling needed in some bathrooms and laundry rooms
- Replacement of sinks in some areas
- Worn and torn furniture required replacing.

Judgment: Substantially compliant

Regulation 28: Fire precautions

All residents had personal emergency evacuation plans (PEEPs) in place, and these had been reviewed recently. These outlined the supports residents needed to evacuate the centre in the event of a fire. It was noted on these documents that some residents required support from two staff, and the other residents required one-to-one staff support to safely evacuate from the centre. There were regular fire drills to test the effectiveness of the procedures and plans. The fire drills included scenarios with the most amount of residents and the least amount of staff on duty to demonstrate that residents could be safely evacuated. The last night-time stimulated drill from May 2022 contained a good level of detail in the report as to how staff carried out the fire drill and any issues that arose during the drill. For example, staff noted that a magnet failed to operate during the fire drill as required and escalated the concern to the maintenance department for corrective action.

Further improvement was required in relation to the fire containment measures in the centre, as self-identified by the provider.

Judgment: Substantially compliant

Regulation 6: Health care

Residents healthcare needs were found to be well supported in this centre. Healthcare plans were detailed, informed by allied professional recommendations and reviews and provided guidance for staff to implement to support residents to achieve their best possible health. For example, healthcare plans were in place, which provided guidance to staff on how to monitor for signs and symptoms of infection and skin break down. A second example observed by the inspector found healthcare professionals routinely evaluated and updated diabetic management plans to provide staff with the most up-to-date guidance for the management of residents' diabetic insulin requirements.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents with assessed behaviour support needs had behaviour support planning arrangements in place. These plans had been created by allied professionals with knowledge and expertise in the area of positive behaviour support. Where residents presented with behaviours of concern, it was noted these were under review and incidents were recorded and reviewed by allied professionals. In addition, mental health supports were in place, and residents were supported to attend appointments and reviews.

Not all staff had completed positive behavioural training, and the person in charge said they were awaiting dates to book staff onto the training programme. In addition, improvement was required by the provider's oversight committees to ensure restriction practices and rights restrictions were reviewed in line with policy. For example, a physically restrictive practice had been referred to the Human Rights Committee at the beginning of the year. Due to delays in the group convening, this referral and review had not yet occurred. The inspector did, however, observe a rights restoration plan in place that documented efforts made to reduce the restraint that the psychology department closely monitored. There were protocols for the restrictions, and the use of restrictions was recorded to ensure that they were for the least amount of time required. There was also evidence that efforts had been made to remove or reduce the restrictions.

Judgment: Substantially compliant

Regulation 8: Protection

There was evidence of the person in charge and staff understanding of national safeguarding vulnerable adults policies and procedures.
Measures had been put in place to protect residents from abuse. This included the

provision of intimate care plans for each resident. In addition, all staff members had received training in the safeguarding of vulnerable adults. There was a clear process regarding the management of allegations of suspected abuse, which included the appointment of a designated officer in the organisation. There were no open safeguarding issues/concerns in the designated centre at the time of the inspection.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for DC5 OSV-0003642

Inspection ID: MON-0034798

Date of inspection: 14/10/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Additional training sessions continue to be scheduled in this quarter and in 2023 to address remaining training gaps impacted by the pandemic. Outstanding training for DC 5 has been booked by the PIC to address the gaps identified. The PIC and CNM3 review training attendance monthly and all training attendance is reported on and reviewed monthly by the Regional management team and where there continue to be barriers and gaps this is reviewed with the PIC & CNM3 and further training sessions will be sourced. All identified training gaps will be refreshed by 30/04/2023. • The PIC has completed supervision with all staff and has scheduled further supervision for 2023.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The progress of some actions have been affected by supply chain issues in UK/EU. The following has been completed • New Furniture has been ordered • Internal walls have been painted. And the remaining actions will be completed by 28/02/2023	

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• New furniture has been ordered.
• The housekeeping supervisor oversees the deep cleaning schedule
• Work on bathrooms and laundry rooms is underway and will be completed by 31/01/2023.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Deep sleep fire drills were carried out during the year and there is a schedule in place for 2023.
• Personal evacuation plans are reviewed after each fire drill and review dates are included on the local evacuation plan.
• A risk assessment is in place on the safe use including storage of Oxygen
• All door closures identified are in progress and will be completed by 31/01/2023

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Additional behavior support training is part of this and outstanding training for DC 5 has been booked by the PIC to address the gaps identified. The PIC and CNM3 review training attendance monthly and all training attendance is reported on and reviewed monthly by the Regional management team.
All behavior support training gaps will be refreshed by 30/04/2023.

Nominations have been sought through advertisement for the Regional Human Rights Committee members and this is being processed with the intention of being operational by 31/03/2023.
A restrictive practice subcommittee of the Positive Behaviour Support Committee (PBSC)

is currently in place since the start of September 2022 to review restrictions and support teams to reduce, eliminate or utilize the least restrictive procedure possible.
All restrictions in DC5 were submitted to this subcommittee and the members are currently working through these and they are in progress.
The committee is working with the PIC and team to review and plan regarding existing restrictions. Ongoing since September 2022
Restrictions are also reviewed locally by the PIC and monthly by the subcommittee. Ongoing.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/04/2023
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	28/02/2023
Regulation 27	The registered provider shall ensure that residents who may	Substantially Compliant	Yellow	28/02/2023

	be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/01/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/04/2023
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	Substantially Compliant	Yellow	30/04/2023

	evidence based practice.			