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:	Glen 3
Name of provider:	Avista CLG
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	11 January 2024
Centre ID:	OSV-0003727
Fieldwork ID:	MON-0041789

About the designated centre

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

The designated centre consists of three bungalows located in a campus setting and provides a residential service for up to 16 residents who have an intellectual disability and require moderate to high support interventions. The centre is located in a suburb of Co. Dublin with access to a variety of local amenities. Residents are supported 24 hours a day by a team comprising of a person in charge, clinical nurse manager, staff nurses, social care workers, healthcare assistants and household staff. Residents are supported to engage in a range of activities which were meaningful to them both in the community and on the campus where the centre was located. The houses in the centre are purpose built and there is a living room, shared dining and kitchen area, a smaller sitting room, two bathrooms, an office and staff room, laundry room and attic space for storage. Each resident had their own bedroom which was decorated in line with their individual preferences and needs. One resident has their own apartment, attached to one of the bungalows by an adjoining door. Each house has a shared garden and patio area which leads on to the main campus gardens.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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 11 January 2024	08:35hrs to 17:15hrs	Erin Clarke	Lead
Thursday 11 January 2024	08:35hrs to 17:15hrs	Michael Keating	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of an enhanced regulatory monitoring approach of the centre. In addition to the regulatory plan for this centre, the inspection was also triggered by the notification of a serious incident which occurred in the centre. In assessing the quality of care and support provided to residents, the inspectors spent time observing residents as they participated in their usual daily activities and observed staff members' engagement with and interactions with residents. As part of the inspection process, the inspectors spoke with the aforementioned staff and reviewed various sources of documentation, which included the statement of purpose, residents' files, centre self-monitoring documentation, incident reports and a number of the centre's policy documents. The inspectors also completed a walk-through of the three bungalows that comprised the centre's premises.

Overall, the inspectors found that significant improvements were required to ensure that the centre was suitable and equipped to meet the needs of all residents living there in terms of residents' needs and expressed wishes and staffing arrangements. Some further improvements were required in governance and management, including information governance, record-keeping, and restrictive practices.

This designated centre consists of three purpose-built large bungalows registered for 16 residents. There were no vacancies on the day of the inspection. The inspectors had the opportunity to meet and spend time with 15 of the 16 residents who lived in the designated centre and to visit all three bungalows. The designated centre is located on a congregated mixed-use campus setting with six other bungalows with an overall capacity of 52 residents. Each bungalow was assigned to accommodate certain support needs. Entry, exit doors and the rear garden doors were secured via a key code or fob at various times to prevent residents from inadvertently leaving the centre or unauthorised access by other persons.

While the centre was located on the outskirts of Dublin city and close to a nearby village, residents mostly relied on transport to leave the campus grounds. This was partly due to poor public transport options, limited pedestrian crossings and footpaths outside of the centre, which led out onto a busy road and also the mobility requirements of residents.

The first bungalow visited by the inspectors accommodated five residents who required support due to complex medical, physical or sensory needs. One resident in this house had additional living space and one-to-one staff in line with their assessed needs. The resident had the sole use of a room opposite their bedroom, which they used as a private living space where they could also have their meals and watch television. A high number of injuries were reported to the Chief Inspector every quarter for this bungalow as a result of self-injurious behaviours. The cause of these behaviours included communication difficulties, unfamiliar staff, overstimulation and difficulty living with other residents. As a result of these

incidents consistently occurring and the review of triggers for some incidents resulting in injury or safeguarding concerns, the inspectors were not assured that the provider had adequately addressed the causes in order to reduce reoccurrence. This is discussed further in the report.

On arrival at the bungalow, the inspectors were welcomed by two staff members and brought into the dining room. A third staff member was also present to support the residents. Residents were having breakfast and engaging in their morning routines. One resident was getting ready to leave the centre to attend their day services, which the inspectors were informed they really enjoyed. Staff were observed kindly speaking with the resident and checking for signs of illness as the resident displayed some symptoms.

The inspectors briefly met with the person in charge, and the service manager explained the purpose of the inspection and requested documentation for review after visiting all the bungalows. The inspectors met with one resident in their separate living room and were introduced by the person in charge. They were recovering from a surgical procedure following a medical emergency that occurred at Christmas time. The resident was being supported one-on-one by a staff member who knew the resident and their needs well. The resident appeared comfortable in the presence of staff and briefly referred to their injury in communication with the inspectors.

The second bungalow also accommodated five residents who had an autistic spectrum disorder, complex mental health needs and those who may require positive behaviour support. This bungalow had a self-contained living area that allowed one resident to set out their living arrangements in a specific manner that best suited their specific needs. This living environment was created by dividing a section at the end of a corridor where a resident had access to a small living area, bedroom and bathroom behind locked doors. The doors contained glass panels so the resident can view the activities of staff and other residents. The inspectors observed this house as busy, with all staff supporting residents to have breakfast and getting ready for the day. While residents did not communicate verbally, the inspectors observed residents making their needs known by leading staff by the hand to an area or activity of interest.

The inspectors spent time with one resident who spent most of their time in their self-contained area of the designated centre due to their specific needs. The single living arrangement included a bedroom with an en-suite bathroom and a living room with a kitchenette. Access to the kitchenette, wardrobes, and the rest of the house was still limited for the resident; however, alternatives had been trialled, and continuous efforts to achieve the least restrictive alternative were ongoing. This included the unlocking of doors for a set time for the resident to access other areas in the centre free from restriction. It was evident that the resident clearly preferred to have set routines, knowledgeable staff, and the ability to have their living quarters sparsely decorated.

While the resident appeared content in other areas of the centre when they were present in the main living areas, the rationale for the separate living was partially

derived from the risk of the resident trying to alter the physical layout of the amenities and furniture in the centre. The provider had reduced the number of environmental restrictions for the resident as anxieties reduced as a result of their low stimulus environment. However, the inspectors found that further reviews were required, in particular from a rights perspective. It was noted that the resident had access to a kitchen with staff support; however, in the morning time, it was observed that the resident was provided with breakfast and tea from the main kitchen. The resident had to wait on the other side of the locked door for staff to return, which was not an optimally person-centred method. While the resident was provided with one-to-one staffing support, the inspectors observed this could not always be possible due to residents requesting their attention while moving between the self-contained area and the main areas. The inspectors were made aware that the resident could access the main kitchen for breakfast based on the resident's will and preference, which can change daily.

The third bungalow visited by the inspectors was home to six residents with a mental health diagnosis and may require positive behaviour support. Residents also needed support with complex medical and physical needs such as epilepsy and mobility issues. The inspectors viewed the residents' bedrooms in this bungalow. These had been highly personalised to reflect residents' interests and tastes. Photographs and residents' preferred items were on display. Many soft furnishings and sensory items, such as blankets, comfort chairs, cuddly items, and objects of reference, were available to residents, which inspectors observed the residents using.

Throughout the day, the inspectors spoke with several staff who spoke compassionately and respectfully about residents and were observed engaging with them in a kind and warm manner. Staff in the bungalows were observed to be attentive, available and present to the residents and spoke to the inspectors about the importance of social activities for some residents. Staff also demonstrated a good understanding of the residents' needs and the associated supports in place, for example, behaviour support plans and healthcare interventions. One staff met with had the role of activities coordinator, and they explained the types of activities, outings and trips that residents liked to go on, particularly on a one-to-one basis with staff as a break away from their peers. Due to the high support needs in the centre, the protected time of the activities coordinator post facilitated these types of activities for residents more frequently. A reported positive impact of more regularly planned off-campus activities for residents, especially those who favoured routines, was that they had become more comfortable and accustomed to trialling different pursuits.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

Historically, this centre has been found to have repeated non-compliance with the regulations, resulting in more frequent inspections and escalation actions to ensure the provider met regulatory requirements. There had been a period of substantial management changes in this designated centre. Most recently, there was a change to the service manager of this centre in October 2023, the third since the renewal of the registration inspection in August 2021. Based on the findings of this inspection, the inspectors concluded that although the centre's governance and management structures were improving in terms of monitoring, they were still not entirely effective. An increased number of staffing vacancies in the centre and the wider campus also presented as a long-standing issue and risk, which had not been resolved despite the many recruitment campaigns organised by the provider.

Considerable non-compliance was identified during an announced inspection to inform a registration decision of the centre in August 2021. The non-compliance was observed in areas of governance, complaints management, staffing levels, restrictive practices, safeguarding, and the promotion of residents' rights. Based on the findings of that inspection and a trend of compliance in this centre, the Chief Inspector proposed to refuse the provider's application to renew the centre's registration.

In response, the provider provided a detailed representation explaining the steps they intended to take to address the failings identified from a governance and quality of care perspective. As a component of this response, the campus's executive and management teams established a governance and oversight committee to supervise the plan's execution, address non-compliance areas, and promote the provision of person-centred support. After some areas of improvement were discovered during a follow-up inspection in December 2021, the centre's registration was renewed through to December 2024.

As part of the regulatory monitoring approach to this centre, a decision was made to carry out a risk-based inspection in March 2023 to assess if the provider had completed its stated actions as submitted and what impact these had on the compliance levels for this centre and the quality of life for residents. The overall findings of that inspection did not assure inspectors that the provider had effective monitoring systems in place to manage and oversee the care and support of the residents, as a high level of non-compliance existed. As a result, a second risk-based inspection was scheduled.

Since the previous inspection of this centre in March, the provider responded to governance issues within the campus by strengthening the governance organisation structure to provide additional support and monitoring functions. Two night managers were recruited in October 2023 who held the post of clinical nurse managers grade two (CMN2). The night managers were based on site from 8pm to 8am to provide clinical support to staff and residents and perform auditing functions. Prior to the commencement of these night managers, out-of-hours support was provided via telephone to night managers located in a different campus operated by the provider. While this centre was located nearby and the night managers were

part of the emergency response for the centre, their presence on campus was not frequent due to work demands. This was a positive change to ensure consistent support due to the complex and varying needs of the residents living within the campus.

In addition to the CNM2s being recruited, an additional CNM3 half-post had been introduced to the campus in January 2024. While the service manager, who reports to the assistant chief executive officer (ACEO), had overall responsibility for the campus, they were assisted by 1.5 whole-time equivalent (WTE) CNM3. There were a total of three persons in charge (CMN2s) on campus, and they were accountable to the CNM3.

The inspectors found evidence of enhanced priority areas for development since the previous inspection. These included a review of rosters to facilitate attendance at staff meetings, the presence of the service manager at staff meetings, consultation with staff, promotion of wellbeing and shared values, human resource input, and development of key performance indicators (KPIs) for managers.

Although there was evidence of good leadership and managerial responses to complaints and incidents in the centre and the appointment of key management positions, these were still in their infancy. As a result, the inspectors found that further improvement was required regarding the monitoring systems in place for the centre.

The inspectors requested to view the reports generated from the provider's legally mandated six-month unannounced visits to the designated centre. The purpose of these visits is to monitor the safety and quality of care and support provided in the designated centre and, as required, to put a plan in place to address any concerns identified during the visit. Whilst having a perspective on quality, safety and compliance with regulations and standards, the registered provider should ensure that any report of their unannounced visit explicitly reflects how systems, practices and procedures impact on outcomes for residents. The inspectors read the report written following the May 2023 visit. They were not satisfied that the provider could be assured as to the quality and safety of care and compliance within the designated centre due to the template being poorly completed and limited details of the findings being recorded.

In addition to the reviews and audits required under the regulations, the inspectors requested to see the provider's quality improvement plans, audits and any other initiatives that evidenced the centre's governance. A written request for these records was presented to the person in charge at 9.30 am while inspectors visited one bungalow. While the inspectors acknowledged that the person in charge had previously committed morning meetings, the information systems in the centre did not facilitate the ease of retrieval of these documents in the absence of the person in charge. Several verbal requests as to the status of these documents were made throughout the inspection. However, a significant delay was experienced, with some records remaining outstanding at 4 pm, when the inspectors concluded the inspection to prepare for feedback.

Some folders and documents presented to the inspectors were not up to date or did not reflect progress made on the campus or areas for improvement identified. For example, the quality improvement plan dated July 2023 stated 47 actions were completed, with only three actions for completion, which did not represent the actions documented elsewhere. The rosters made available to the inspectors for review were not legible in many places and did not properly capture the non-permanent staff that worked shifts in the centre. The inspectors were told that data stored in other folders and electronically had more current and pertinent information and were properly maintained when these concerns were brought up during the feedback session.

Regulation 15: Staffing

Similar to previous inspections in this centre, the efforts of the provider to maintain and recruit staff remained an ongoing challenge. Actions taken by the provider to come in line with the whole-time equivalents (WTE) as set out in the statement of purpose, which the centre was registered against, had not been effective. These included recruitment drives, open days, online advertising and social media posts. Management advised that recruitment was ongoing and that although staff had been hired, staff resignations and various types of leave meant it was difficult to maintain the required staffing levels. Inspectors were also aware that similar vacancies existed within the other bungalow on campus.

At the time of the inspection the registered provider had vacancies across all grades consisting of three nurses, four healthcare assistants and one social care worker, representing around a third of the required staffing levels. In their statement of purpose, the provider had committed to having ten WTE nurses, 15 healthcare workers and 2.5 social care workers employed in the centre to provide safe care.

Although management was attempting to ensure continuity of care and support through the use of regular relief, in particular with residents who would struggle to have their support needs met by unfamiliar staff, this was not always possible with the number of shifts to cover. The inspectors spoke with the management team at the feedback session about their concerns regarding the provider's capacity to provide staffing levels and model of care as outlined in their statement of purpose. Inspectors acknowledged that recruitment difficulties were being affected by external hiring challenges, but this was a repeated finding for the centre for the sixth consecutive inspection and required significant review.

Judgment: Not compliant

Regulation 21: Records

Not all records solicited by the inspectors for the purpose of monitoring and inspection were of a suitable standard or made available in a timely manner. These records were requested across the day of inspection, and the inspectors offered a number of opportunities for them to be presented. The inspectors were informed that some of these records could not be located. In the case of compatibility assessments, inspectors were told these had been completed by a previous manager and may be stored electronically but could not be retrieved. Meetings that occurred outside of the designated centre but referenced the resident, for examples, minutes of ADT (admission, discharge and transfer) meetings, were not available for inspectors to review.

Communication systems between key stakeholders and departments required improvement to ensure up-to-date information was available in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

As previously mentioned, although there was evidence of good leadership and managerial responses to complaints and incidents in the centre and the appointment of key management positions, these were still in their infancy. As a result, the inspectors found that further improvement was required regarding the monitoring systems in place for the centre.

Inspectors were also presented with a detailed quality improvement plan during feedback following a complaint made by a staff member who left the centre after a number of weeks of working in one bungalow. The content of the complaint raised concerns in several areas, affecting the quality and safety of the care being provided to residents. The action plan demonstrated that the concern was taken seriously, and learning was implemented to address the areas raised. The inspectors suggested that due to the late stage of receiving the report, the record-keeping of quality improvement initiatives were reviewed in order to support the provider in producing evidence of compliance during inspections carried out on behalf of the Chief Inspector.

The inspectors found deficits in the provider's monitoring systems, namely the six-month unannounced visits to the centre, tracking of action progress, and addressing actions in a timely manner. This was a repeated finding for this centre and also within other designated centres on this campus. In contrast, the 2022 annual review completed in January 2023 by the quality department accurately and objectively assessed the centre's performance and identified that the centre's oversight was ineffective. For example, it was identified that staff training, risk management, assessment of needs, complaints, supervision and fire safety measures all required review. The quality and safety officer found that while the campus has an oversight committee, progress was slow in addressing issues of concern while examining the centre's governance. The report further identified that while six-month audits had

been undertaken, they did not identify several issues and where actions had been identified and assigned, several actions remained outstanding.

The inspectors raised similar concerns about the quality of the provider's unannounced visits to the centre. Although there was space on the report to highlight improvements made in previously indicated areas, as well as provide an overview of residents' lived experiences and staff conversations, these sections were either left unfinished or only contained partial information. The management of complaints, for example, was the only action included in the status update to the action plan created by the yearly review, despite the fact that 31 areas had been identified for action.

Improvement was also required to the timeframes of the six-month unannounced visits as well as the actions contained within the report. An unannounced visit had last taken place in October 2022 and again in May 2023. The minimum time gap between visits should be six months; however, seven months had lapsed between the last two visits. Furthermore, at the time of the inspection, another visit had not been completed despite being eight months since the previous one.

Judgment: Substantially compliant

Quality and safety

The inspectors were concerned regarding the provider's overall progress with achieving and sustaining compliance with regulations and standards to ensure residents' quality of care and access to safe services. In addition, as outlined in the previous section of this report, improvements were also required in positive behavioural support and restrictive practices. Following the receipt of a serious incident, the inspectors identified areas of good practice in the management of this incident.

There was ongoing guidance from allied health professionals around supporting and managing behaviours of concern for residents. While there was a vacant post for a clinical nurse specialist in behaviours of concern for the campus, support had been sought from the wider organisation, with psychological input being evident. For example, a behavioural therapist visited the centre to support staff and review support plans. These visits also increased following a serious incident where a resident received a life-changing injury.

The registered provider had policies and procedures in place around the management of risk. An incident that occurred in the centre had been reported in a timely manner, an incident report form had been completed for this incident, and a serious critical incident review was underway due to the severity of the incident.

The inspectors found that the provider's emergency response to the injury was well managed from a clinical, allied health and risk management perspective. Additional

staffing hours had been implemented to support the resident, and a range of medical professionals had been involved in the resident's care, overseen and coordinated by the campus management and nursing team. At the time of the inspection, a critical incident review of the accident was underway. The inspectors were informed that while self-injurious behaviours may have led to the injury, comorbidity factors existed due to a degenerative condition.

There was a high level of environmental restrictions implemented within the centre, which included exit doors being locked across the three buildings, modified clothing, sensor mats, and a partitioned living section. The inspectors found a good level of oversight and scrutiny of restriction practices overall. The inspectors found that the restrictive practices were supported by appropriate risk assessments, which were reviewed on a regular basis. Risk assessments in place monitored and evaluated the risks and benefits of the restriction on residents' wellbeing and included the various control measures in place to reduce or mitigate the risk. Some improvements, as discussed under Regulation 7 Positive Behavioural Support, were required to better demonstrate that restrictive practices were all managed in a way that promoted the rights of each resident to live in a restraint-free environment.

A resident had been previously assessed as requiring an alternative living environment. While the provider considered potential options for this and reviewed this matter regularly, the resident's living environment remained unchanged. This matter had been specifically highlighted in previous inspections conducted by the Chief Inspector in August due to the recommendations that this resident's living environment was not optimal for the wellbeing of the resident.

Regulation 26: Risk management procedures

There were a number of risk management systems in place in the centre with evidence of good oversight of ongoing risks. A centre-specific risk register was in place, which identified a number of specific risks and was reviewed on a regular basis. Individualised risk assessments were also in place, which were also updated regularly to ensure risks were identified and assessed. The risk register also referenced areas for improvement as found on inspection and from the provider's own audits, such as staffing, rights infringements and non-compliance with the regulations.

The provider was recording incidents on the National Incident Management System (NIMS). Incidents were being reviewed by senior management, and learning was being identified to ensure relevant risks were mitigated as required.

Incidents that had happened in the centre were taken into account when reviewing risk assessments. A review of a serious incident was being examined by the Serious Incident Management Team (SIMT) for investigation and learning.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspectors followed up on a previously submitted action by the provider, where they committed to reviewing residents' preferences and the suitability of current accommodation in the centre to meet all resident's assessed needs. It was well-known and documented in the centre that one resident did not live optimally with others and was considered a priority for alternative accommodation. However, the inspectors were not assured that a timebound plan for this transition was in place. Requests for minutes of meetings where the resident was discussed in terms of their assessed needs and expressed preferences were not available for review, and the inspectors had not received any further update to the previous inspection in March 2023, where it was communicated to the inspector that the resident was being considered for single occupancy living.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspectors found overall that the 19 reported restrictive practices and a sample of behavioural support plans reviewed were well managed with appropriate systems of oversight and monitoring with the ongoing purpose of reducing and eliminating restrictions.

The inspectors found staff to be knowledgeable regarding restrictive practices. However, during the inspection, the inspectors observed a staff member physically diverting two residents by the arm in the designated centre. While this was a supportive interaction, it was not an agreed physical intervention based on a behavioural or safety assessment and this type of intervention required review.

Regarding the restrictive environment for one resident, the service manager agreed that more exploratory work was required to ensure that a person-centred approach to restrictive practices was in place. Furthermore, it was not evident that all restrictive practices were the least restrictive; for example, some restrictive practices were in place to protect other residents and may not be required in other living situations.

Judgment: Substantially 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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Glen 3 OSV-0003727

Inspection ID: MON-0041789

Date of inspection: 11/01/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider remains committed to ensure that residents receive continuity of care and support in line with assessed needs of the residents. • SCW position has been filled and commenced in post on 15.02.2024. • One Care staff position has been recruited and will commence on 1.4.24. • One care staff vacancy has been filled by a permanent relief staff ensuring consistency. • Currently recruiting Staff nurses via Rezoomo, - interview date set early March 2024 • Avista recruitment open day held on 21.2.24. • CPL Agency have been contracted to recruit for care staff vacancies. • Regular relief staff who are familiar with the designated Centre have been assigned to fill in a vacancy and will be rostered consistently until the vacancy is filled. • Rosters have changed from weekly to monthly planning which will allow for booking in advance of relief staff to cover a vacancy and ensure information is recorded on the roster. • Rosters have also moved to an online live system to ensure clear and up to date information present.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The Provider will ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector. • A full review of the storage system of records is being undertaken in the designated Centre to ensure up-to-date information is available in the centre and compliant with	

records management.

• The provider is assured that all relevant information, including compatibility assessments, is now maintained on site by the PIC.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The registered provider has established and commenced implementation of management systems in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

• The registered provider is implementing local Standard Operating Procedures across the centre, to ensure consistent management and oversight.

• A six-monthly provider audit was complete 31.01.2024. The provider has met with the PIC and discussed actions assigned from this audit.

• Provider visits are scheduled and will be completed in line with timeframes outlined in the regulation.

• An annual review of 2023 was completed with a meeting facilitated to discuss findings and actions with the PIC, PPIM and Service Manager

• Shared learning from Provider visits and annual reviews will be applied across the centre.

• All actions will be assigned, monitored and updated on a log which will be reviewed at a monthly meeting with the PIC & PPIM. Dates have been scheduled throughout 2024.

• The PPIM will provide updates monthly to the Service Manager following the meeting with the PIC. Dates have been scheduled throughout 2024.

• KPIs have been developed for the new night manager role and this will support the governance and monitoring system within the designated center. This will be reviewed regularly at night manager meetings with the PPIM.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• Each person has a comprehensive current assessment of need and care plan in place.

• An additional assessment (IPNA) will be complete where it is identified an individual may have a preference for a change of living environment.

• The MDT has met fortnightly since this individual's needs changed in December 2023 and are now scheduled monthly. The individual's needs are now being reassessed to establish a new baseline and introduce support required for daily living. The team has been working together with the individual, their family and outside agencies to establish

how to best meet the individual's needs. It is unclear at this early stage what type of accommodation will best support this individual.

• Due to the individuals changing needs, the provider will look at the possibility of planning and developing a single occupancy apartment on campus to suit the individual's needs, while remaining on the housing list. This has been discussed with the MDT and timeline of year end 2025 agreed.

• The provider is committed to continuing to work with the local housing authority for one individual as referenced in the report. An up-to-date OT report will be submitted to the local housing authority by the 30.04.24, as this individual has experienced a life changing event in recent months. The Individual's IPNA is currently being amended and reviewed, with MDT consultation. Progress will be captured in the individual's personal plan.

• The MDT will next meet on 9.4.2024 and continue to assess the individual's changing needs. A referral to an independent advocate will be submitted as agreed by the MDT team.

• External support services have been contacted and secured, who specialise in supporting individuals with specific needs. An appointment has been arranged for the 19th March 2024 with one agency to review strategies around daily living activities within the home environment. An assessment and guidance have been completed from another external agency exploring ways for staff to support the individual with the changed needs.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• The Residents' existing support needs have been reviewed with the local team and has been updated in the individuals care plans.

• A referral to CNS in positive behaviour has been submitted and the individual is currently receiving support from the CNS.

• The provider is committed to ensuring where restrictive practices are in place that it is least restrictive and are reviewed regularly by the MDT.

• Restrictive Practices are reviewed frequently in line with timelines as agreed by the MDT, the last review was on 11.1.24.

• All updates in restrictive reduction plans are communicated to the local team for implementation.

• Further training dates for Restrictive Practice Training have been set for all teams in March 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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/05/2024
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 than full-time basis.	Not Compliant	Orange	31/03/2024
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as	Not Compliant	Orange	30/04/2024

	specified in Schedule 3 are maintained and are available for inspection by the chief inspector.			
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	31/05/2024
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/03/2024
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably	Not Compliant	Orange	30/04/2024

	practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2025
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	31/05/2024
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/05/2024