Report of an inspection of a Designated Centre for Disabilities (Adults)

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>No 2 Seaholly</th>
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</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Brothers of Charity Services Ireland CLG</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Cork</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Short Notice Announced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>10 June 2020</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0004572</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0029575</td>
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About the designated centre

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

No. 2 Seaholly is comprised of three detached, and two semi-detached, bungalows. The number of bedrooms in each bungalow ranges from four to six. Each bungalow has its own garden area. The centre is located on a campus with a number of other designated centres, on the outskirts of Cork city. The centre is registered to provide a residential service to 25 people aged 18 years and older. For the minority of residents this service is provided on a shared care or respite basis. Each resident of No. 2 Seaholly has been diagnosed as functioning within the range associated with a moderate to severe level of intellectual disability. Some residents also have a diagnosis of autism. It is stated in the statement of purpose that each resident requires full support in activities of daily living. The centre is staffed at all times.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 20 |
How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (hereafter referred to as inspectors) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:
<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday 10 June 2020</td>
<td>11:00hrs to 16:30hrs</td>
<td>Elaine McKeown</td>
<td>Lead</td>
</tr>
<tr>
<td>Wednesday 10 June 2020</td>
<td>11:00hrs to 16:30hrs</td>
<td>Lisa Redmond</td>
<td>Support</td>
</tr>
</tbody>
</table>
What residents told us and what inspectors observed

Each inspector met with residents in the house in which the inspector was based during the inspection.

One inspector met briefly with two residents living in one of the houses in the designated centre. One resident sat with the inspector and a staff member for a couple of minutes and appeared curious as to the inspectors presence in the centre. The resident appeared relaxed and was comfortable in the presence of staff members. The inspector met with a second resident on their arrival back to the centre following a drive. The resident was observed to be smiling and laughing on their return. Interactions between staff and residents were observed to be respectful in nature.

The other inspector met with two residents who were being supported by two staff in another house. Staff encouraged the residents to talk to the inspector about their planned activities. Both residents were aware of the inspector’s scheduled visit and called the inspector by name when they met. Staff outlined how the residents enjoyed gardening activities in the recent good weather, planting a herb garden and other garden maintenance at the rear of the house. The other resident was resting in bed when the inspector arrived. Staff supported the resident to have breakfast of their choice. The inspector met with this resident before they left the designated centre to go on a planned spin with day service staff. This resident was encouraged to tell the inspector of their plans to celebrate their birthday the following day with cake and other treats and staff explained plans for the resident to be taken see a family member. There was also plans for the resident to visit another family member at the weekend who they have not met since the start of the government restrictions. The inspector observed good communication between the residents and staff in the house. The residents were observed to be supported by staff in a professional and respectful manner. The staff team in this house also supported two other residents on a shared care basis, both of whom were being supported by family members at the time of the inspection.

Capacity and capability

The person in charge was contacted the day prior to this inspection informing them of the planned inspection, outlining the required documentation to be reviewed and the format of the inspection. Two inspectors carried out the inspection as this designated centre comprises of five houses. The inspection was conducted to review progress with actions outlined following the previous inspection in December 2019. Each inspector was based in a separate house during this inspection. The report reflects the findings of the inspectors in two of the five houses in this designated
The inspectors reviewed the actual and planned roster for two houses in the designated centre. Residents were supported by a team of core staff and a regular relief panel of staff members who knew the residents well. During the inspection it was observed that residents appeared comfortable and relaxed in the presence of staff. The number and skill mix of staff members was as stated in the statement of purpose. The rota in one of the houses also reflected the flexibility of staff to respond to changing numbers of residents due to shared care arrangements for two residents. The provider ensured a regular staff team supported the residents during the night from the start of the government restrictions. This enhanced the support to residents by ensuring experienced staff were on duty at all times in the designated centre. A multi-disciplinary team service review of the residents living in one of the community houses had been completed in May 2020. This report identified that a review of the staffing skill mix in this house was required to ensure that the skill mix of staff members was appropriate and in line with the assessed needs of residents. The person in charge informed the inspectors that additional training needs had been identified for staff. Some on line training had already commenced and the person in charge advised training was scheduled to be completed by July 2020.

The Provider had ensured that a six monthly unannounced visit to review the quality and safety of care and supports in the designated centre, had been completed during COVID-19. It was evident that the provider had adapted how this was completed due to COVID-19 in line with public health guidance. This included the completion of remote discussions with staff members in each house, and a separate report being being compiled for each of the five houses in the designated centre. The inspectors reviewed these reports for the two houses that were inspected. The person in charge outlined the oversight of the six monthly reports with each house. The person in charge and the social care leader of each house review the reports and actions. The person in charge reports back to the sector manager when the actions are completed. However, not all actions had not been progressed or completed in the most recent reports that were reviewed by the inspectors, including one action that was deemed by the auditor of the report on 17 April 2020 as being urgently required to be completed. This will be outlined in greater detail in the next section of the report. In one of the houses, staff spoken with, identified that the current placement of three residents was not in line with their assessed needs and no longer deemed suitable. This was also identified in the multidisciplinary team service review report for this house which was completed in May 2020, which had been commissioned due to compatibility issues with residents in this house in 2019. However, this was not documented in the designated centre’s most recent six monthly unannounced visit to the designated centre. Therefore, it was not clearly documented what actions were being taken to find a more suitable placement for residents, or additional supports that may be required until a more suitable placement is found.
Regulation 15: Staffing

There was an actual and planned rota in each house. However, further review of the qualifications and skill mix appropriate to the assessed needs of the residents was required, in line with recommendations from the multi-disciplinary service review.

Judgment: Substantially compliant

Regulation 23: Governance and management

It was not demonstrated that the management systems in place ensured that the service provided was appropriate to residents needs and effectively monitored.

Judgment: Not compliant

Quality and safety

Efforts had been made to provide for the assessed needs of the residents in the designated centre. The provider had ensured residents were supported by a consistent staff team while the government restrictions were imposed due to the Covid-19 pandemic. However, it was evident that improvement was needed in a number of areas during this inspection. These included the protection against infection, fire safety and positive behaviour support.

On arrival to the designated centre, the inspectors adhered to guidance from the person in charge and wore face masks while in the designated centre in line with public health guidelines for healthcare workers. The inspectors also provided their temperature details to staff in the designated centre. A record of staff temperatures had been taken at the start of each shift however it was noted that on a number of occasions, staff temperatures had not been taken 6 hourly during their shift in line with the guidance provided to staff members from the Health Protection Surveillance Centre (HPSC).

The provider had facilitated information sharing with staff by developing a COVID-19 folder in the designated centre to provide guidance to staff and residents regarding the infection control measures and standard precautions required to prevent the spread of COVID-19. It was identified that the guidance provided to staff members from the HPSC had not been updated since 22 April 2020. Staff members spoken
with told the inspector that they were not aware of updated guidance from the HPSC or where to access this information. It was noted that the cleaning schedule provided in this document was not being implemented in the designated centre. Although a cleaning roster was in place, it did not include all areas identified for cleaning in the HPSC guidance provided to staff. The cleaning roster noted three consecutive days where a number of areas including door handles had not been cleaned. It was also observed that cleaning was documented as occurring once daily, which was not in line with the cleaning schedule in the HPSC guidance provided. In addition, one inspector noted that the table provided for them to work from during the inspection was heavily stained. Due to COVID-19 restrictions the inspector did not complete a walk around in this community house, however it was observed that the area provided to the inspector was dusty and that cob webs were visible.

The provider had ensured that fire doors and closures had been installed in the designated centre since the last inspection. These were evident in the two houses that the inspectors were located in. The inspectors acknowledged that the required action to ensure compliance with regulation 28: Fire precautions which was identified in the previous inspection was still outstanding due to unprecedented circumstances. The completion of a report by an external consultant on fire compliance issues in the designated centre was unable to be completed during the current government restrictions and the provider has kept the Health Information and Quality Authority (HIQA) informed of the delays in completing this action. The comprehensive review of all five houses in the designated centre is now scheduled to take place on 19 June 2020. The inspectors reviewed the fire procedures and protocols in place in the designated centre, and spoke with staff members about fire evacuation. It was evident that one bedroom in one of the houses was an inner room however this bedroom was not occupied by a resident at the time of the inspection and there were no plans for this bedroom to be used. A personal emergency evacuation plan was in place for each resident. It was identified that all residents required staff assistance in the event of evacuation in the event of a fire. It was noted that the documented evacuation procedures did not accurately reflect the procedure used by staff members. For example, one resident was reported to require two staff members due to the risk of abscending on evacuation. Staff members reported that on evacuation of this resident, staff members will put the resident onto the bus and put their seat belt on. This was not reflected in this resident’s personal emergency evacuation plan. It was also noted that only one staff member was on night duty and therefore supervision by a second staff as outlined in the plan was not possible. The inspector reviewed the documentation of fire evacuation drills carried out in this house since the last inspection. A night time simulated drill had been completed in May 2020. It was noted that on this occasion it was not possible to evacuate all of the residents with one staff member and that a second staff had to be called to provide assistance. There was no evidence that a successful night time evacuation had been completed since the last inspection which reflected the staffing levels in this house at night. On occasions during fire drills, it was also documented that residents may not co-operate with the evacuation. The inspector reviewed the fire evacuation procedure in place which did not provide any guidance to staff members that a second staff may be required for evacuation. It was also unclear how the provider would ensure that a second staff member
required on a night time evacuation would be aware of the evacuation procedures required for these residents as they would be coming from elsewhere within the campus. In the other house a minimal staffing drill had not been completed with all four residents. This had been identified by the auditor of the six monthly report completed on 17 April 2020 and actioned as being urgently required to be completed. This had action had not been completed at the time of the inspection and staff spoken to on the day of the inspection were unaware of the action.

The provider had ensured that there was a centre specific risk register which had been updated to reflect the risk of Covid-19. This also included a contingency plan for the house in the event of a resident requiring isolation. However, at the time of inspection, the person in charge was unaware of the provider’s amendment to the risk policy in April 2020 which had an addendum relating to the risks relating to Covid-19. This was not available for staff to review in the designated centre and staff spoken with were unaware of this document at the time of the inspection. This will be actioned under regulation 23: Governance and management.

The person in charge outlined the ongoing review by the staff team of personal outcome goals for all residents with the support of a facilitator. The inspector reviewed the goals in one house which had been amended to reflect the current restrictions in place. Residents were being supported to complete independent living skills and activities in the house. In addition, staff outlined how one resident was being supported to enjoy a regular weekly activity in the house. The staff had been able to secure ingredients and packaging from the resident’s favourite restaurant. They were able to freeze the produce and facilitated the resident weekly to continue to enjoy their meal for the last few months. The person in charge also outlined how the occupational therapy department were collaborating to develop videos to support residents to complete different life skills. There are also advanced plans to transfer one resident to a more suitable designated centre and the person in charge advised that the resident is currently being supported to ensure their safety on use of the stairs with the physiotherapy department prior to their transfer. Another resident is currently awaiting the identification of a more suitable location by the provider before they are transferred out of this designated centre.

The previous inspection of the designated centre noted that not all residents had multidisciplinary input into the review of their personal plans in the last 12 months. The inspector reviewed an assessment of a resident’s health, personal and social care needs however this had not been dated and there was no evidence that it had been reviewed by an appropriate health professional. It was evident that staff working in the designated centre knew the residents well. The inspector spent some time speaking with one of the designated centre’s team leaders and it was evident that they had a good understand of the residents’ needs. Staff spoken with informed the inspector that a comprehensive assessment of residents’ health personal and social care needs by an appropriate healthcare professional had not been completed in 2019 for residents living in one of the community houses. The rationale for this was that a mutli-disciplinary service review of the supports being provided to residents was being carried out at this time. Although these actions were outstanding from the previous inspection, the progress was consistent with the time lines provided to HIQA in the previous inspection report. According to the report,
this review was delayed by seven months and completed on 01 May 2020. Although the action plan within this report had not yet been completed, a multidisciplinary meeting to discuss the supports provided to these residents had been scheduled for July 2020.

It had been noted in both the designated centre’s most recent six monthly unannounced visit and on discussion with staff members that there had been a significant decrease in the presentation of behaviours that challenge and the use of restrictive practices in one of the houses. It was evident that staff members were aware of the behavioural supports required for residents. During the inspection, the inspector could hear a resident vocalising loudly in the designated centre. When asked, a staff member reported that the resident liked to vocalise on arrival to the centre and that the times the resident arrived to the centre had been altered to ensure that they could vocalise in line with their wishes. Staff were aware that this could be a trigger for other residents living in the centre and had ensured that the resident had sufficient time in the centre alone where they could happily vocalise on arrival back to the centre. The inspector reviewed the behavioural support plan in place for one resident and noted that the staff members were not provided with clear guidance on how to support the resident to manage behaviour that is challenging. Although the plan was reviewed monthly by the person in charge and members of the behavioural support team, the original plan for the management of the resident’s behaviours was dated March 2014. It was not evident if the resident had been subject to a comprehensive assessment of their behavioural support needs since March 2014. Due to the volume of review documentation carried out monthly since March 2014, the guidance for staff members was not clear, as the original plan was not updated following review. It was noted within the behaviour support plan that agreed reactive strategies were in place for the resident. In addition to the behaviour support plan a seclusion protocol had been put in place for the resident which had been sanctioned by the rights restriction committee in 2014. However, it was noted that in addition to the monthly reviews, there was no evidence that the use of seclusion had been review annually by the behavioural support committee in line with the organisations seclusion policy. It was noted that the use of seclusion was not documented and reviewed on the seclusion monitoring form in this policy.

The inspectors reviewed a sample of the safeguarding plans in place for residents living in the designated centre. On discussion with staff members, it was evident that additional control measures had been put in place to protect residents in line with the recommendations of the safeguarding plan. This included an extra staff member being allocated to provide support in the unlikely event that all residents were awake before the arrival of day shift staff. Staff members spoken with were aware of the safeguarding measures in place for the resident. In addition, the provider had implemented measures since the last inspection to ensure residents finances were securely managed.

During the inspection, the inspectors were informed of the different methods used to support the residents to keep in contact with their families during the government restrictions which included regular video calls. One resident had also been supported to see a close relative in an open area outside the designated centre while adhering to social distancing measures. Social stories had also been used to help support
anxieties that some residents presented with in the last few months.

<table>
<thead>
<tr>
<th>Regulation 26: Risk management procedures</th>
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<tbody>
<tr>
<td>The provider had systems in place for the assessment, management and ongoing review of risk.</td>
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<tr>
<td>Judgment: Compliant</td>
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<thead>
<tr>
<th>Regulation 27: Protection against infection</th>
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<tbody>
<tr>
<td>The provider had policies in place, however, staff practices did not always adhere to the guidelines as per the provider’s guidance documents and updated policies to ensure the safety of all residents</td>
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<tr>
<td>Judgment: Not compliant</td>
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<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
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<tbody>
<tr>
<td>The provider had not ensured that minimal staffing fire drills had been carried out in all houses. Not all residents' personal emergency plans reflected the procedures followed by staff.</td>
</tr>
<tr>
<td>Judgment: Not compliant</td>
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<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and personal plan</th>
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<tbody>
<tr>
<td>While the provider had completed a service review, not all residents had been supported to have an annual review completed.</td>
</tr>
<tr>
<td>Judgment: Substantially compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
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<tr>
<td>The healthcare needs of the residents were assessed and they had good access to a range of healthcare services, such as general practitioners, healthcare professionals and consultants.</td>
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<tr>
<td>Judgment: Compliant</td>
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<thead>
<tr>
<th>Regulation 7: Positive behavioural support</th>
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<tbody>
<tr>
<td>Not all restrictive practices in place in the designated centre had been reviewed in line with the providers policy and national guidelines.</td>
</tr>
<tr>
<td>Judgment: Not compliant</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 8: Protection</th>
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<tbody>
<tr>
<td>The provider had appropriate arrangements in place to safeguard residents from harm or abuse.</td>
</tr>
<tr>
<td>Judgment: Compliant</td>
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<tr>
<th>Regulation 9: Residents' rights</th>
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<tbody>
<tr>
<td>The provider had ensured that the residents' privacy and dignity was respected</td>
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<tr>
<td>Judgment: Compliant</td>
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</table>
### Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 27: Protection against infection</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Compliant</td>
</tr>
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</table>
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. Specific to that regulation, **Measurable** so that they can monitor progress, **Achievable and Realistic**, and **Time 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:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tbody>
<tr>
<td>Regulation 15: Staffing</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 15: Staffing:
- The person in Charge will ensure that the services staffing procedures in line with the staff complement in the Statement of Purpose, are fully implemented in all areas at the Centre.
- The staffing budget is reviewed quarterly by the Person in Charge and Financial Manager.
- The Person in Charge carries out quarterly staffing audits of all the properties in the Centre to ensure the staff skills are adequate to meet the needs of the people they are providing support to. Last audit completed: 22/06/20.
- Additional training was identified as required for 1 staff team in a Full Service Review Report and a deadline to complete same has been set for 31/07/20.
- The Person in Charge has included the Social Care Leaders meeting agenda: updates in relation to the following on
  - Updates on concerns on staffing levels
  - Details of planned activities that did not go ahead due to staffing complement
  - Details of roster commitments not filled due to staff re-assignment
  - Updates on resources allocated and not used since the last meeting.

| Regulation 23: Governance and management | Not Compliant |

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

- The Provider has put in place a COVID 19 Planning Group to ensure all staff are updated on the latest Infection Control Measures to be put in place in the Centre. The person in charge has attended Weekly Covid 19 meetings with the Senior Management team for the purpose of updating documentation and the sharing of relevant information. An agenda is set, agreed and information is shared with all areas of the Service via periodic updates.

- The Provider has ensured that all service areas received Covid 19 File 1 Updates (Guidance Sheets) and Covid 19 Guidance File 2 (Guidance Documents) were circulated on 30/06/20

- The Person in Charge ensures Social Care Leaders meetings continues during Covid 19 restrictions via Skype.

- The Provider has ensured that HPSC guidance in relation to cleaning is set out in Guidance Sheets and the PIC oversees the implementation of these procedures in all properties in No.2 seaholly

- The Person in Charge ensures all houses received updated policy updates when made available from the Provider, confirmation that updates were completed in all areas was received on 21/05/20

- The Person in Charge is based on site and makes regular visits to all of the houses in No.2 Seaholly. This was carried out during Covid Restrictions via Social Distancing meetings, skype calls and 1:1 meetings with Social Care leaders. Visits to properties recommenced on the 15/06/20 as per public health guidelines.

- The Provider has arranged for the Person in Charge to carry out quarterly audits on Restrictive practices in use in the Centre, Risk register audits and staffing skills mix audits.

- The Person in Charge receives a weekly service area report of significant issues.

- The Provider arranged for the Person in Charge to attend all Annual Multi-Disciplinary review meetings, restrictive practice sanctioning and review meetings.

- Regular meetings are held with the PPIM and Director of Services in relation to compliance.

- Provider 6 monthly unannounced visits are in place and actions are clearly defined, the Person in Charge works with the Social Care Leader to ensure actions are time framed and implemented.

- The Provider visits will include a review of multidisciplinary recommendations and progression of agreed actions in relation to the Centre and residents compatibilities, where relevant.
• The Provider will seek to make application to the Authority to sub-divide the Centre into smaller groups of houses at the next re-registration date to further support the PIC and PPIM in the management, monitoring, audit and review of the Centre.

![Table]

<table>
<thead>
<tr>
<th>Regulation 27: Protection against infection</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 27: Protection against infection:

• The Provider has set out clear guidance for staff in relation to Infection Prevention and Control. The Person in Charge has ensured all service areas including residents who may 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.

• The Provider Covid 19 guidance File 1 was issued to all properties in No.2 Seaholly. Updates to Guidance File 1 and Covid 19 Guidance File 2 were circulated on 30/06/20 which included updated Guidelines for the services for the prevention and management of Coronavirus.

• The Provider has ensured that HPSC guidance has been set out in COVID-19 Guidance Sheets for staff in relation to cleaning is in place in all properties in No.2 Seaholly. The PIC has ensured that these were reviewed and discussed and minuted at a Social Care Leaders meeting held on 01/07/20

![Table]

<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• A comprehensive review of Fire safety in all five houses, commissioned by the Provider was planned to commence in March 2020 and was re-scheduled to commence on the 19/06/20. This review is to include the completion of a Fire Safety Risk Assessment.

• The Fire Safety Risk Assessment will be completed by 16/07/20, a time-bound action plan addressing all recommendations from the review by 31 August 2020 will be submitted to the Authority.

• The Emergency Response Protocol for evacuation at night was reviewed by the Person in Charge and Night Supervisor on the 29/06/20 to update detail on houses named to
support each other in the event of an evacuation at night.

- All Fire drills have been completed within the agreed timeframes.
- Two Fire drills with minimum staffing levels detailed as required in the unannounced 6 monthly inspections will be completed by 08/07/20

<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and personal plan</th>
<th>Substantially Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</td>
<td></td>
</tr>
<tr>
<td>• The Provider has ensured that all residents have an individual assessment and Personal plan carried out annually, and that these are reviewed quarterly and as required throughout the year. All plans were reviewed and dated in the Centre in May 2020 to reflect Covid 19 restrictions, goals were reviewed and adapted to reflect limited community activities.</td>
<td></td>
</tr>
<tr>
<td>• An Annual multi-Disciplinary Review scheduled for 25/03/20 for 1 house was re-scheduled as a result of Covid 19 restrictions and is planned for 09/07/20. All other houses within the Centre have had 2020 Annual multi-Disciplinary Reviews completed.</td>
<td></td>
</tr>
<tr>
<td>• An updated Personal Outcomes Measures report was sent to all houses on 23/06/2020</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 7: Positive behavioural support</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</td>
<td></td>
</tr>
<tr>
<td>• A multidisciplinary review of the whole service was commissioned by the PIC to identify what systems changes were required to support reduction in behaviours that challenge and seclusion and increased quality of life for this resident and co-residents. Person in Charge, Social Care Leader and Relevant Multi-Disciplinary team attended a meeting on 08/07/20 to discuss the implementation of recommendations and the timeframe.</td>
<td></td>
</tr>
<tr>
<td>• The frontline team are now using the Seclusion Policy and Procedure Document Appendix B.</td>
<td></td>
</tr>
<tr>
<td>• The Co-ordinator of Behaviour Support Service and Senior Psychologists will examine the procedure for the review of the Behaviour Support Plans by 04/09/2020</td>
<td></td>
</tr>
<tr>
<td>• The Service’s Residential Services Quality Group will discuss the process of</td>
<td></td>
</tr>
</tbody>
</table>
documenting Positive Behaviour Support Plans to ensure that these are easy to follow and provide continuity in this Designated Centre.
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulated requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15(1)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/07/2020</td>
</tr>
<tr>
<td>Regulation 23(1)(c)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/07/2020</td>
</tr>
<tr>
<td>Regulation 27</td>
<td>The registered provider shall ensure that</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/07/2020</td>
</tr>
</tbody>
</table>
residents who may 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.

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Requirement</th>
<th>Compliant/Non-Compliant</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>28(1)</td>
<td>The registered provider shall ensure that effective fire safety management systems are in place.</td>
<td>Substantially Compliant</td>
<td>31/08/2020</td>
</tr>
<tr>
<td>28(2)(b)(ii)</td>
<td>The registered provider shall make adequate arrangements for reviewing fire precautions.</td>
<td>Substantially Compliant</td>
<td>08/07/2020</td>
</tr>
<tr>
<td>28(3)(d)</td>
<td>The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.</td>
<td>Not Compliant</td>
<td>08/07/2020</td>
</tr>
<tr>
<td>28(4)(b)</td>
<td>The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in</td>
<td>Substantially Compliant</td>
<td>08/07/2020</td>
</tr>
</tbody>
</table>
so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

| Regulation 05(1)(b) | The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis. | Substantially Compliant | Yellow | 09/07/2020 |

| Regulation 05(6)(a) | 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 multidisciplinary. | Substantially Compliant | Yellow | 09/07/2020 |

| 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 | Not Compliant | Orange | 09/07/2020 |
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.

| 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. | Not Compliant | Orange | 09/07/2020 |

| Regulation 05(7)(c) | The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales. | Not Compliant | Orange | 09/07/2020 |

| Regulation 07(4) | The registered provider shall ensure that, where | Not Compliant | Orange | 04/09/2020 |
restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.

| Regulation 07(5)(c) | The person in charge shall ensure that, where a resident’s behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used. | Substantially Compliant | Yellow | 30/09/2020 |