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:	No.1 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	05 August 2021
Centre ID:	OSV-0004574
Fieldwork ID:	MON-0033413

About the designated centre

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

This centre is located on a campus in close proximity to a major city. It is within access to shops, public transport and public amenities. This designated centre was set up to provide a specialist service for people with an intellectual disability, including autism. The designated centre has been adapted to meet residents' assessed needs and is a four-bedroom, single storey premises. The designated centre has a kitchen and separate dining room, a large day room / television room, a relaxation room, a sensory room, two bathrooms and a shower room. There is also a staff office and utility room. Three young male adults reside in the designated centre. Each resident has their own bedroom. One bedroom is used for staff to sleep over at night in addition to a waking night staff. There was an integrated day service for residents - two residents attending on site and one resident attending off site. Residents are encouraged to live an active, meaningful, everyday life by participating in household tasks, social and leisure activities. There is an outside garden area to the rear and side of the designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

Date	Times of Inspection	Inspector	Role
Thursday 5 August 2021	9:00 am to 6:00 pm	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

This inspection was completed to monitor the compliance of the registered provider with the regulations under the Health Act 2007 and to assist in the recommendation for the renewal of registration of the centre for three years. The inspection took place during the COVID-19 pandemic. The provider was given advance notice of the inspection. This afforded sufficient time to inform the residents of the inspection and to have the required documentation available. Infection control guidelines were adhered to during the inspection including the use of PPE and social distancing.

On arrival the inspector met with the person participating in management, whom was currently covering for the person in charge in their absence. As part of this initial meeting they spoke of the identified need for oversight in the centre. In recent weeks a change in the team leader position had occurred. In this time a periodic service review had been completed within the centre and an action plan developed to address the areas of non-compliance. This included appropriate staff supervision, residents' personal plans and review of fire safety systems.

The inspector based themselves in an office to complete documentation review to reduce the impact of the inspection on the three resident's present in the centre. The inspector did however call to the centre and meet with residents and staff on duty.

On arrival, one resident was sitting in their favourite spot in the lobby. With the support of staff this resident had completed a visual schedule for their activities during the day. They were to commence with a walk in the local woods. Staff stated this was a favoured activity of all the residents. A cabinet had been placed in the entrance lobby to keep all the required boots and jackets organised. When the resident returned from their walk they were supported by staff to freshen up and make a healthy smoothie.

Another resident was in the dining room having their breakfast. This resident liked to have their space private, staff had supported this and provided the resident with a coded access to their bedroom and private relaxation room. The resident gave the inspector permission to look around this space when they were out and about on their activities. They were supported by staff through the use of a manual signing system to prepare for their day and activities. They were supported to get their bag ready. Their plan was to go for walk in the forest, then on for a spin and to go get something nice for lunch. They signed goodbye to the inspector and headed off with two staff.

One resident was having a chilled out morning. They were soaking in the bath after their breakfast. They then went to their bedroom to relax and listen to music. They brought staff the communication photos and showed them photos of their chosen activities for the day. All staff were observed supporting residents to communicate in their unique way and spoke clearly of each resident's communication needs. These

needs were also expressed clearly within each personal plan.

Management systems in place in the designated centre did not ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. A number of areas of non-compliance were identified on the day of inspection which required review. This included the training needs of staff, notification of incidents and supervision of staff. Systems to ensure the safety of residents required review and additional oversight required review including the administration and storage of medicinal products and the assessment and identification of risk. This was discussed with the governance team and director of services as part of feedback on the day of inspection. The regulations reviewed as part of the inspection will be discussed in more detail throughout the remainder of the report.

Capacity and capability

The inspector completed the inspection of No.1 Seaholly, to monitor compliance with the regulations and to assist on the recommendations to renew the registration of the centre for a period of three years. The findings on this inspection demonstrated that the governance and management of this centre did not provide effective oversight to ensure that residents were safe and in receipt of a good quality of service and improvements were required. Whilst the provider had implemented a number of actions to address the non-compliance in the quality and safety of the service, continued actions were required to ensure oversight was maintained and the roles and responsibility of all staff members was clear.

The registered provider had appointed a suitably qualified and experienced person in charge to oversee the management of the centre. The person in charge was supported in their role by an appointed social care leader. On the day of inspection the person in charge was not present, HIQA had been informed that the person participating in management would hold responsibility of the centre in their absence. However, on the day of the inspection an alternative person was noted in documentation as providing cover and also an alternative person was communicated by staff as providing this cover in the absence of the person in charge.

The appointed person in charge had the governance responsibility over a number of centres operated by the registered provider. Evidence was not presented on the day of inspection to demonstrate that effective systems were in place to maintain oversight of service provision. Areas requiring improvement were not identified and addressed in a timely manner, such as, medication management and review of complaints. It was also noted on the day of inspection that a new social care leader had been appointed to the centre in the weeks prior to the inspection.

The registered provider had not ensured the annual review of service provision had been completed in accordance with regulatory requirement. Whilst the completion of this was the delegated duty of the person in charge as assigned by the provider, the

person participating in management was not aware if this had been completed in January 2021 as required. In the absence of the person in charge and the awareness of its completion, the annual review for 2020 was completed in July 2021. Due to the delay in the completion of the report this addressed a number of issues arising in 2021 rather than in the year to be reviewed. A six monthly unannounced visit to the centre had been completed in May of 2021. Whilst an action plan had been developed to address areas of non-compliance identified during the visit, actions were set out to be the responsibility of the social care leader with no clear evidence of oversight by the person in charge. In the weeks prior to the inspection the registered provider had self-identified the need for increased governance oversight in the centre including actions plans arising. A template was currently in development organisationally to assist the governance team with oversight of service provision. Pending approval of this, the current social care leader and person participating in management had completed a review of the service provided to residents and commenced a number of actions to achieve compliance. This included a full review of resident's personal plans and the completion of infection control monitoring.

Residents were supported in their day to day life by a staff team who were aware of their needs and interests. Where a vacancy arose on the roster this was filled by a regular relief staff or agency staff to maintain consistency and continuity of care. There was not evidence that the person in charge or person participating in management had evaluated the effectiveness of the staffing levels in place throughout the day. On a number of occasions staff members had noted in daily records that activities had to be changed due to non-attendance of staff.

The supervision of the staff team was the delegated responsibility of the social care leader. Formal supervisory meetings were not being completed in accordance with organisational policy. In the previous year, where a staff member did raise a concern or issue arising in the centre there was no evidence that this had been addressed or escalated to the person in charge. The provider was unable to provide supervisory records between the person in charge and social care leader on the day of inspection. When team meetings did occur the person in charge was not always in attendance to ensure the roles and responsibilities of the full staff team were clear, and that staffing concerns were addressed in a timely manner.

On the day of the inspection, the inspector was unable to review the up to date training records of the staff team. There was a number of training areas which the provider had deemed to be mandatory such as infection control and safeguarding vulnerable adults from abuse. The records provided did not evidence that all staff were supported and facilitated to attend this training. The provider did state that up to date records would be provided in the day post inspection to the inspector. These records were not provided.

Whilst the residents were supported to submit a complaint using the organisational complaints policy. Adherence to same was not consistently present. Where a complaint had been made with respect to two areas, one area had not been addressed despite the complaint being closed. Also there was no evidence of governance overview of all complaints made. Where a staff member submitted a

complaint on the behalf of a resident, the staff name was not noted to allow for a complete review of complaint and ensure the satisfaction of the complainant.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had ensured a full application for the renewal of registration had been submitted to HIQA in a timely manner.

Judgment: Compliant

Regulation 14: Persons in charge

Whilst the registered provider had appointed a suitably qualified and experienced person in charge to the centre, due to their governance oversight within the organisation they did not have effective governance systems in place.

Judgment: Substantially compliant

Regulation 15: Staffing

The staffing levels which had been appointed to the centre by the registered provider was appropriate to the assessed needs of the residents. However, on a number of occasions it was noted that residents could not attend an activity due to the unplanned absence of a staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

It was not evidenced that all staff had been supported to access appropriate training to meet these individual needs of residents.

The person in charge had also not ensured that members of the staff team received appropriate supervision in accordance with organisational policy.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had ensured the designated centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured effective oversight of this centre. The roles and responsibility of members of the governance team were not clear and required clarity. Management systems in place in the designated centre did not ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development and review of the statement of purpose, incorporating the information required under Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not ensured the notification of all notifiable events were notified in accordance with their regulatory responsibilities.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had ensured an effective complaints system was in place. Residents were supported to submit a complaint as required, however adherence to

the complaints procedure required review.

Judgment: Substantially compliant

Quality and safety

The inspector reviewed the quality and safety of the service provided to individuals whilst residing in No.1 Seaholly. Individuals were supported to engage in a range of meaningful activities both within the centre and in the local community. However, actions was required to address a number of areas including medication management and risk.

On the day of inspection the centre was a hive of activity with residents coming and going throughout the day. One resident was supported to go for a walk in the local woods. Another was supported to for a community drive records provided to the inspector on the day evidenced that all residents were supported to partake in a range of activities on a daily basis. Resident's interests were supported and encouraged such as listening to music, art and family visits.

Following a recent review, all residents were now supported to have an individualised plan in place which reflected their individual needs. The social care leader in conjunction with the residents and the keyworkers had completed a review of all personal plans to ensure they reflected the current needs of the residents. These plans incorporated a holistic approach to support needs and incorporated guidance from relevant members of the multi-disciplinary team including speech and language and dietician intervention. Personal goals were in place, taking into account the current national restrictions. Staff completed a daily report book and significant issues log, along with priority outcomes to monitor progression of personal goals and skills training.

The registered provider ensured that the premises were designed to meet the assessed needs of residents, of sound construction and was clean and suitably decorated. A recent refurbishment had occurred including new furniture and a fresh coat of paint. The location of one bedroom door required review to ensure the privacy of the resident was promoted at all times. This had been relocated from hallway to the main living area. From a fire safety perspective this also required review. One resident had requested privacy around their area in the centre and this had been facilitated by the provider.

This inspection took place during the COVID 19 pandemic. All staff were observed to adhere to the current national guidance including the use of PPE equipment, and social distancing. An organisational contingency plan was in place to ensure all staff were aware of procedures to adhere in a suspected or confirmed case of COVID 19 for staff and residents. Residents were observed to be encouraged to wear face masks when out and about and to wash their hands on return to the centre.

The registered provider had ensured effective systems were in place to ensure the centre was operated in a safe manner. The registered provider had ensured that each resident was assisted to protect themselves from abuse. Where a safeguarding concern was identified, measures were implemented to protect the individual from all forms of abuse. There was clear evidence of ongoing review of any concern arising. Improvements were required with respect to clearly documenting the safeguarding concern present. This was required to ensure the staff team supporting residents were aware of the potential risk and safeguarding measures in place.

The registered provider ensured that there was a risk management policy in place. Systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies required review. Whilst risk assessments had been completed and recently reviewed for the identified individual risks of residents, a risk register to address the environmental risk within the centre was not present. Control measures in place to address such risks as slips, trips and falls were not provided for review on the day of inspection.

When completing a review of medication it was evident that the person in charge had not ensured that effective systems were in place for the administration and storage of medication. A tablet crusher was present in the drug press located in the staff office and had been used as residue was present, however no resident was prescribed crushed medication. Where discrepancies were noted in stock checks of as required medications, this was not escalated with no explanation in place for same. A review of this was required.

The person in charge ensured that if required appropriate supports were in place to support and respond to behaviour that is challenging. All staff were aware of procedures to adhere to for specific concerns such as interactions, withdrawal and seclusion. The social care leader had introduced measures to ensure that where a restrictive practice was in use this was done so in the least restrictive manner for the shortest duration required. A full review of restrictive practice had been completed and presented to the relevant committee for review. This was also discussed as part of recent team meeting.

Regulation 10: Communication

The registered provider had ensured that each resident was assisted and supported at all times to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider had ensured the provision of the following for residents:

(a) access to facilities for occupation and recreation;

(b) opportunities to participate in activities in accordance with their

interests, capacities and developmental needs;

(c) supports to develop and maintain personal relationships and

Judgment: Compliant

Regulation 17: Premises

The registered provider ensured that the premises were designed to meet the assessed needs of residents, of sound construction and was clean and suitably decorated. A recent refurbishment had occurred. The location of one bedroom door required review to ensure the privacy of the resident was promoted at all times.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide in respect of the designated centre and ensured that a copy was provided to each resident.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there was a risk management policy in place. Systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies required review. A risk register to address the environmental risk within the centre was not present.

Judgment: Not compliant

Regulation 27: Protection against infection

Overall, the registered provider ensured that residents who may be at risk from a health care associated infection were protected and that precautions and systems were in place in relation to the COVID-19 pandemic. An infection control audit and cleaning schedule had recently been introduced in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety management systems are in place, this incorporated staff training, fire fighting equipment.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured that effective systems were in place for the administration and storage of medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Following a recent review, all residents were now supported to have an individualised plan in place which reflected there individual needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge ensured that if required appropriate supports were in place to support and respond to behaviour that is challenging.

Where a restrictive practice was in use this was done so in the least restrictive manner for the shortest duration required.

Judgment: Compliant

Regulation 8: Protection

The registered provider ensured that each resident was assisted and supported to develop knowledge and self awareness required for keeping safe. However, some improvement was required to ensure the safeguarding risk present was clear.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that was respectful of all residents valuing their individualism. Residents were consulted in the day to day operations of the centre and consulted on all aspects of their support needs.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No.1 Seaholly OSV-0004574

Inspection ID: MON-0033413

Date of inspection: 05/08/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The Provider has reviewed the existing structures and standardised systems in place to support the Person in Charge to discharge their duties. The Centre has its own Team Leader who, as front line manager works the roster alongside the Team, has protected time off roster to assist the Person in Charge in discharging the PIC duties. The provider has taken the following actions to remedy weaknesses in the system. 1. A full time Team Leader was assigned for a fixed timeframe to assist in addressing gaps in system identified during the review. 2. A new Team Leader was appointed to maintain the systems following this review 3. The Provider is working to finalise the introduction of a more localised Person in Charge arrangement for the Centre which will reduce the number of Centres assigned to the Person in Charge and allow the Person in Charge to work alongside the team to ensure greater operational management of the Service. [30 November 2021] 4. The Provider has ensured that a new PIC to PPIM audit tool is introduced to the Centre to be reviewed at intervals between six monthly Provider visits to the Centre. This audit tool will concentrate in review of evidence of robust operational management systems are operated by the PIC in the Centre.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The Provider has ensured that the Person in Charge and the new Team Leader are fully aware of the agreed staff roster for the Centre which designed to ensure meaningful activities and supports are available to residents in the Centre 2. The Provider has ensured that the Person in Charge and Team Leader are aware of	

the minimum staffing levels that must be maintain in the Centre in the event of absence of core staff members and difficulties in recruitment
3. The Person in Charge and Team Leader will ensure that a wider pool of relief staff is identified to support the Centre in period of recruitment difficulties
4. The Person in Charge and Team Leader will ensure that where the Centre has to operate at minimum staffing levels and planned activities need to change, that the alternative activities are recorded in the Centre this will be evidenced in the daily recording notes.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The Person Participating in the Management of the Centre, in the absence of the Person in Charge, has ensured that the Training Matrix was updated and gaps identified to the Training Department for the necessary booking to be planned [9 September 2021]
• All staff due training/refresher training are booked on this training at the earliest date available.
• The Provider and PPIM will identify alternative training options to ensure that staff are facilitated in attending trainings as scheduled where backfill arrangements on the roster may prove difficult i.e. delivery of trainings at scheduled Team meetings in the centre.
• The staff training matrix will be kept updated by the Person in Charge
• The Person in Charge will ensure that a timetable of staff supervision and the records of staff supervisions is maintained in line with Organisational Policy

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider has reviewed its current oversight system to ensure safe and effective services are in operation in the Centre and to identify any weakness in the system. This involved reviewing the robustness of the following controls:-
• Services Quality Systems Department Oversight of the quality of Person Centred Planning with focus on ensuring meaningful goal setting
• Nurse Input to the Review of Health Care Management Plans for Residents
• Annual review of Personal Plans by multidisciplinary professionals
• Oversight of Fire Procedures and Environmental Health Checks by the Facilities Department
• Annual Reviews in Designated Centres overseen by the Services Quality Systems Department
• Provider 6 monthly visits to the Centre overseen by the Services Quality Systems

Department - This 6 monthly visit process mirrors the HIQA inspection in that PICs are issued with a draft Report and can come back to the Reviewer on factual accuracy. The Reviewer sends a copy to the PPIM and the Quality Department if there are no amendments required. The PIC is required to sign off the Report and develop an action plan to address identified apparent weaknesses.
• The Provider has a Provider/PIC Forum in the Region to review key issues and to address system improvement issues meets once a month and is chaired by the Services Quality Co-Ordinator.
• The Provider monitors action progression from HIQA inspections compliance
• The Provider has a National Provider Representative Forum which monitors trends, shares learning, identifies barriers, raises concerns and assists Regions to meet timelines.
Following this review the Provider will
1. Clarify roles and responsibilities of staff team members, Team Leader, PIC and PPIM, ensuring these are communicated to all, and form part of the individuals Performance Management System
2. The Provider will ensure that all team members are familiar with the fact that the Sector Manager is responsible for the discharge of PIC duties in the absence of the PIC
3. The Provider has ensured that a PIC/PPIM audit has been developed and will be reviewed in between Provider 6 monthly visits. This will ensure there is regular oversight of compliance with regulations in the Centre.
4. The Provider will ensure that the Annual Report is completed on a timely basis and captures issues relevant to the year under review.
5. The Provider will ensure that all actions arising from 6 monthly provider visits, Annual Review and PIC audits are appropriately assigned and evidenced as completed on a timely basis during follow up meetings with the Person in Charge who will be required to evidence completion.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. The complaints log will be reviewed to
- ensure that the identify all persons who raise concern on behalf of residents is included to ensure feedback on the resolution of the complaint and that the log can be completed on the satisfaction or otherwise of the outcome of the complaint.
- to ensure all elements of the compliant have been appropriately dealt with
2. The Provider will review the Complaints Process Policy to ensure it clarifies at what stage the complaint is closed and to log satisfaction or otherwise of the complainant at the point of closure.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A risk assessment is now in place for the current position of the door. (6/08/2021)
The facilities manager has reviewed the fire safety controls in place in relation to this bedroom. The outcome of this review is that the resident has two escape routes from this bedroom both with 30 minute fire rated doors. One is to a fire protected corridor and the second door leading to a living room area is a 30 minute fire rated free swinging fire door. These measures are adequate to ensure fire risks can be managed. (31/08/2021)
The door in question is used primarily as a control measure in relation to privacy issues. A review is currently underway analysing the number of times residents wake during the night and the time they wake in the morning. Following the this review potential for roster commencement and finishing times will be considered as an alternative to manage the potential risks. (30/09/2021)
A meeting is scheduled with The Desiginated Officer and the MDT to review the potenial risks to the resident with any changes in the location of the door used to access/egress from bedroom. (30/09/2021)
Following this recommendation a final decision will be made on the location of the door. (30/09/2021)

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A full review of all environmental risks is underway following which an update of the risk register will be completed by the 30/09/2021

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The person in charge will ensure that
1. all staff are reminded that medications must be administered as prescribed and that tablet crushers should not be used in the administration of medications unless prescribed route of administration.
2. The medication in questions was reviewed by the GP and has now been prescribed as to be crushed.
3. A Cleaning protocol is in place for the tablet Crusher. (9/08/2021)
4. The centre has appropriate practices in relation to the control, safe storage and stock checking of medications including the escalating reports of all discrepancies to the PPIM via medication error report forms.
5. Regular medication audits are carried out in the Centre and all apparent weaknesses noted and discussed at Team meetings and entered into the risk register as appropriate.

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The Provider has ensured that the following measures are in place to ensure staff team are aware of the potential safeguarding risk in the Centre:- - Safeguarding plans clearly identify the safeguarding concerns present in the Centre. - Potential Risks are identified in staff induction folder and - Potential Risks are identified in the risk register of the Centre, as appropriate	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	30/11/2021
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.	Substantially Compliant	Yellow	29/10/2021
Regulation	The person in	Not Compliant	Orange	30/11/2021

16(1)(a)	charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/11/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2021
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	17/09/2021
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	Not Compliant	Orange	17/09/2021

	monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	17/09/2021
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	17/09/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/09/2021
Regulation 29(4)(a)	The person in charge shall ensure that the	Not Compliant	Orange	31/08/2021

	designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/08/2021
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	29/10/2021
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints	Substantially Compliant	Yellow	29/10/2021

	including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	17/09/2021