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:	Juniper Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Roscommon
Type of inspection:	Unannounced
Date of inspection:	04 April 2023
Centre ID:	OSV-0004696
Fieldwork ID:	MON-0035505

About the designated centre

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

Juniper services comprised four houses and could provide a residential service to up to seven adults with a primary diagnosis of intellectual disability and who require mild to moderate support. The centre could also support residents with mental health needs, and behavioural needs. The service provided residents with individualised support and residents could remain at home as they wish or could also attend day services from Monday to Friday. All four house were located in rural settings, some distance from each other. Each house had transport to facilitate outings in the community. Each resident had their own bedroom which was decorated to the residents' taste and choice. Residents were supported 7 days a week by a person in charge, social care workers and care assistants. Residents were also supported at night by a sleep-in staff member in each house.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 4 April 2023	09:30hrs to 18:20hrs	Angela McCormack	Lead
Tuesday 4 April 2023	09:30hrs to 18:20hrs	Eilish Browne	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations since the last inspection of Juniper services by the Health Information and Quality Authority (HIQA) in July 2021. This inspection found that there was a significant deterioration in compliance with the regulations since the previous inspection. In particular, risks that could impact the safety of residents in one location had not been appropriately identified and managed. This will be expanded on throughout the report.

Juniper comprised of four houses located around county Roscommon. One house provided full-time residential care to two residents and three houses provided residential care to one resident each. There were a further two beds (one each over two houses) that could provide respite services if needed. There were five residents living in Juniper at the time of inspection, with no respite provided at that time. Inspectors got to speak with three residents throughout the course of the inspection. One resident was observed walking freely around their house, but inspectors did not get to meet with them. In addition, one resident was at an external day service on the day and when asked over the telephone by staff, they said that they did not want to meet with inspectors on their return home. This was respected. In addition, inspectors met and spoke with staff who were working in three houses throughout the course of the day.

On arrival to the centre inspectors met with the person in charge in an office adjacent to one of the houses. The person in charge was available throughout the day and facilitated the inspection. Inspectors visited all four houses throughout the day.

Through a review of documentation, observations and discussions with residents and staff, it was found that residents were offered choices about how to spend their day and about what activities they would like to take part in. Activities and interests that residents enjoyed included; going to the gym, yoga classes, horse-riding, being involved in their own business, gardening and going to local amenities. There was transport available to support residents to access activities in the wider community if they chose to.

One resident spent some time speaking with inspectors. They spoke about their interests and spoke about their work and activities that they enjoyed. They spoke fondly about one particular staff member who supported them. They showed inspectors photographs that they had taken on their mobile device and spoke about their life. When asked, the resident said that they did not like living in Juniper and they did not feel safe, saying that they were 'petrified' at times due to the behaviours of a peer. They said that the additional staffing that was put in place recently helped matters, and that they got to do things that they liked to do outside of the house whenever they chose to. The local management team were aware of

this issue and were actively reviewing the future living arrangements with residents.

Another two residents were met with in their homes. Residents showed inspectors around their homes, including their bedrooms. Residents' bedrooms were decorated in line with residents' individual preferences and had personal effects and furnishings of their choosing in place. One resident had recently redecorated their bedroom and staff spoke about how the resident chose the colour scheme. Another resident proudly showed the inspector their collection of sports jerseys. They spoke about watching sports on television with a staff member the night before. Residents were observed freely moving around their homes and they appeared comfortable with staff and in their surroundings. One resident spent time going through photographs in their personal plan with the inspector. When asked, they talked about activities that they enjoyed such as cooking, horse-riding and gardening.

In one of the houses, residents had access to a spacious sensory garden with a trampoline to the rear garden. Although inspectors did not speak with the resident in this house, the resident was observed enjoying their afternoon moving freely and comfortably in their garden. There was also a polytunnel located in the garden. Staff members spoken with reported that the resident enjoyed gardening. Residents enjoyed outings including trips to the playground, going on picnics, swimming, walks in the local forest park and one resident recently visited Glencar Waterfall. There were no visiting restrictions in the designated centre and there was evidence that residents enjoyed regular contact and visits from family and friends.

Overall, residents were found to be involved in meaningful activities to them. They were supported to do jobs and experience work and training that met their individual interests. Residents were facilitated to try out new interests also. For example, one resident was commencing a yoga class on the evening of inspection. Residents were supported to maintain links with their families, friends and the wider community. One resident spoke about phone contact they had with their close family member who lived abroad, and they spoke about visiting relatives the previous weekend. Another resident received an invitation to a family occasion and they were observed speaking with staff about what they would wear to the occasion.

Staff spoken with talked about residents' individual needs, preferences and about how choices were made. Some residents used visual schedules and objects of reference to help with communication. Staff were observed supporting residents in a caring manner, and it was evident that residents were familiar with staff and comfortable around them. Staff members spoken with appeared knowledgeable about each residents' likes and interests. Care plans in general were comprehensive; however there were some gaps in the safeguarding and behaviour plans documentation. This will be discussed later in the report.

In general, the houses were found to be spacious and homely. However, some aspects of the premises in one location in particular, required improvements in the maintenance and upkeep. In addition, fire risks were evident in two houses. These will be discussed in the next sections of the report.

Overall, inspectors found that Juniper services provided person-centred care and support and that staff were familiar with residents' individual preferences. However, due to incompatibility between residents in one location, safeguarding concerns occurred and led to some residents not feeling safe at times. In addition, in another location risks that affected one resident's right to privacy and fire safety risks had not been appropriately identified and managed.

The next sections of the report describe the governance and management arrangements and about how this impacts on the quality and safety of care and support provided in the designated centre.

Capacity and capability

Overall, inspectors found that the management and oversight of the centre did not ensure that all of the houses that made up Juniper services provided a safe and high quality service. There were non-compliances found in a number of regulations including; fire safety, risk management, staff training, premises and residents' rights. These will be discussed throughout the report.

On discussion with the person in charge at the start of the inspection, inspectors found that the person in charge had a large remit and had operational responsibility for a large number of areas. Inspectors were informed that the person in charge was an 'area manager', and that they had management responsibility for seven day services and one other designated centre, in addition to Juniper services. This arrangement was not reflective of management and person in charge arrangements in place by the provider in other parts of the country. It was found throughout the inspection, that these arrangements in Juniper services did not ensure effective oversight and monitoring of the quality and safety of care provided, which led to some risks to residents not being identified and responded to. The compliance plan of the inspection by HIQA in July 2021 stated that there would be two team leaders appointed to support the area manager; however these posts were appointed to cover the North Roscommon area and neither of these team leaders were working in Juniper services. Therefore the impact of this was not evident in this designated centre. Inspectors were informed that there was a social care leader in one house and a 'shift lead' in another house; however this did not include any additional times off shift to support in the operational management of the centre.

The person in charge described their arrangements for oversight of Juniper service as attending team meetings, visiting each location at least once per month and having weekly telephone calls. Staff spoken with said they could contact the person in charge at any time, and that they were accessible to them when required. However, despite this, the arrangements for oversight for each location were not effective in ensuring that risks and actions for quality improvement were appropriately identified and followed up in a timely manner.

In addition, the local management audits and reviews of practices in the centre

were not robust. Local management reviews did not always identify actions for quality improvement nor effectively identify risks. For example; while it was noted that the person in charge signed off on risk assessments as reviewed, inspectors found that control measures that were noted on risk assessments were not accurate and this had not been identified through the reviews. Furthermore, it was found that incidents that involved property destruction were not appropriately recorded and escalated to the local manager through the online incident reporting system. All of this led to a significant risk in one house whereby it had not been identified that some fire doors would not be effective in containing fires, since an incident that reportedly occurred last November.

While it was found that the provider unannounced six monthly visits identified some actions to comply with the regulations, it was found that some actions were non-specific and the time-frames identified had lapsed for some actions. In particular, it was noted that actions related to governance and management and premises in the last two provider reports were vague and not specific as to what was required. This meant that issues with premises in one location were not completed in a timely manner. In addition, specific actions to strengthen the governance of the centre were not clearly identified. This meant that there was no progress made throughout 2022 to strengthen the governance of the centre, despite it being mentioned in the last two provider reports and in the provider's annual review of the service.

There were arrangements in place for staff to access training. However, it was unclear from the documentation in place if staff had ever received some of the training required, or if it was refresher training that was due. From a review of the records given to inspectors, there were significant gaps noted across the areas reviewed.

Staffing arrangements appeared to be effective and consistent. Some staffing increases had been implemented in response to safeguarding and behavioural issues in two locations. However, the statement of purpose for the centre had not been reviewed since July 2021 and therefore the details of the staffing full-time equivalent (FTE) was inaccurate.

In general, the oversight and monitoring arrangements in the centre were not effective in identifying risks actions required to bring about improvements in the centre in a timely manner.

Regulation 15: Staffing

The centre was staffed with a skill mix of social care workers and care assistants. Inspectors found on the day, that staffing arrangements for supporting residents with their individual needs was appropriate.

While there was one vacancy in one location of the centre, the arrangements for cover while the recruitment was in progress supported the resident.

Judgment: Compliant

Regulation 16: Training and staff development

On review of the staff training matrix a number of training gaps were identified for some staff as follows:

- Nine staff required Behaviour management training
- Five staff required training in Fire safety
- Five staff required Infection prevention and control training
- Four staff required National safeguarding vulnerable adults at risk of abuse training.

Judgment: Not compliant

Regulation 23: Governance and management

The oversight and monitoring of the centre required significant improvements to ensure that it was effective in identifying areas for improvement and compliance. The following was found;

- The compliance plan from the July 2021 HIQA inspection had not been implemented as neither of the team leaders appointed to support the area manager who was the person in charge, were assigned to Juniper services.
- The statement of purpose had not been reviewed at intervals of not less than one year as required in the regulations.
- Fire risks that were evident in two houses had not been appropriately identified and managed to ensure that fire containment measures were effective at all times.
- Maintenance work to ensure that the premises were well maintained and hygienic was not followed up and addressed in a timely manner.
- Audits did not identify clear, specific and time bound actions for quality improvement.
- Incidents were not reported and documented consistently. For example; one incident involving property damage and which created fire risks was not documented and recorded on the incident reporting system.
- Some risks in one location were not appropriately identified and assessed.
- There were gaps in some documentation, with some documents not available in the centre at the time of inspection. This included a safeguarding plan for one resident.
- There were gaps in staff training.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had not been reviewed since July 2021 and did not include accurate information about the staffing full time equivalents. The staffing WTE was updated on the day of inspection.

Judgment: Substantially compliant

Quality and safety

This inspection found that in general, residents were supported to take part in activities that they enjoyed and were meaningful to them. However, some risks relating to fire, premises and rights were not effectively identified or assessed. In addition, documentation regarding safeguarding was not up-to-date and available in the centre, and one behaviour support plan did not include actions that staff spoke about to support a resident.

The Chief Inspector of Social Services had been notified about three concerns of a safeguarding nature in 2023 which occurred in one location of the centre. There was evidence that measures were in place to minimise safeguarding concerns such as increased staffing and environmental changes. There were ongoing reviews occurring about the compatibility of residents living together, and inspectors were informed that there were reviews ongoing about future living arrangements for some residents. However, there was no definite plan agreed, and one resident told inspectors that they were 'petrified' at times. In addition, a safeguarding plan for one resident was not in place on the day of inspection. While there was no evidence that this lack of documentation directly impacted on residents at this time, the oversight in ensuring that the most up-to-date documentation was in place, was not effective.

In general, each resident was found to be supported in accordance with their needs and were offered choices in their day-to-day lives. A sample of residents' files reviewed found that assessments of needs were completed to assess health, personal and social care needs. Annual reviews occurred with the participation of residents and their family representatives. One resident's annual review was due at the time of inspection, and staff spoke about planning this with the resident and described how the priorities for the coming year would be identified with the resident.

Residents who required support with behaviours of concern had plans in place which included multidisciplinary team (MDT) input. Regular MDT meetings occurred where

required, which reviewed the resident's care needs, some of which were complex. However, it was found that what staff described as doing in response to some behaviours was not consistent with what was included on the support plan for one resident.

In addition, it was found that one residents' right to privacy was impacted and staff said that the resident did not like this. Staff described looking through a hole in the bedroom door at times when they had concerns about the resident's welfare, when the resident didn't respond to staff. While staff spoke about how they were trying to balance the safety and rights of the resident, this practice had not been identified as a rights' issue. Furthermore, this had not been discussed at MDT meetings so that the risks and possible alternatives to mitigate the identified risks could be explored. In the feedback meeting, the provider assured inspectors that this practice would not continue.

There were risk assessments in place for identified risks. Inspectors were informed that a risk affecting one resident had been escalated to senior management. This related to safety and welfare risks. Inspectors found that when incidents or changes occurred in this house, risks had not been appropriately re- assessed, reviewed and documented. For example; one resident had sustained an injury on the stairs when alone in the house and while inspectors were informed that this was under review with consideration given to the resident moving to a downstairs bedroom, the risk assessment had not been reviewed and updated to reflect this incident. In addition, risks that staff spoke about were not specifically assessed which meant that one residents' rights to privacy had not been identified as being impacted due to the practices in place, reportedly since November 2022.

The oversight of fire safety in Juniper services was not effective. While there were arrangements in place for fire safety including; fire doors, emergency lighting and fire-fighting equipment, in one location some fire doors were broken. This included the door handle in one resident's bedroom fire door which was removed since November 2022. This was of particular concern as this resident chose to smoke in the house and the fire containment measures were ineffective. This had not been reported through the incident reporting system and had not been identified as a fire containment risk. In addition, in another location inspectors observed, and were informed, that a door wedge was used at times to keep a fire door open, so that the resident could be supervised when staff were in the office area. Inspectors were informed that a self-closing door was required for this room. They said that the person in charge was aware of this and that they were waiting for this new door.

In summary, this inspection found that the arrangements for the monitoring and oversight of the centre did not ensure that risks to residents were effectively identified and managed. This impacted on the quality of care and support provided in some locations.

Regulation 13: General welfare and development

Residents' general welfare and development was promoted with residents having access to leisure and recreational activities of their choosing. This included activities in the wider community.

Judgment: Compliant

Regulation 17: Premises

There were a number of actions required to ensure that the premises were safe and to a high standard. One house in particular required a number of actions to be completed to ensure that it was well maintained, safe and hygienic. The following issues were found;

- A radiator in the kitchen in one house was hanging off the wall.
- One wall in the kitchen of one house was damp and peeling. This was reportedly under review at the time of inspection and the cause of water leak had yet to be established.
- Some fire doors had handles missing or were broken in one house. These were repaired on the day when identified by inspectors, with photographic evidence supplied post inspection.
- There were small nails sticking out from the side panel of the stairs in one house.
- There were some aspects of hygiene risks evident in one house. For example; broken tiles in the hallway, mops stored in mop buckets in a bathroom, cobwebs in some rooms, finger marks around light switches in some rooms and one other house had scuff marks on several doors in the house.

Judgment: Not compliant

Regulation 26: Risk management procedures

Some risks that were evident on the day of inspection had not been appropriately identified and managed. These included;

- Fire containment risks in two houses. For example; the use of a door wedge to hold open a fire door in one house and broken fire doors in another location.
- Specific risks that staff spoke about affecting a resident's welfare and safety had not been appropriately reviewed and assessed to establish what control measures might be required which would replace staff viewing the resident through a hole in the bedroom door, against their wishes. In addition, there was no evidence that risks assessments had been re-assessed following incidents that occurred.

- An incident involving property destruction had not been recorded through the incident management system. This meant that fire safety and privacy risks were not identified in one house.
- While there was evidence of the person in charge signing off as reviewing risk assessments, this did not include a qualitative review as additional control measures required to mitigate some risks were not identified and recorded.

Judgment: Not compliant

Regulation 28: Fire precautions

The following was found in relation to fire safety;

- In one location, some fire doors were broken, with one fire door on a resident's bedroom missing a door handle, which left the door ineffective. The person in charge addressed this on the evening of the inspection by getting two door handles replaced. However, this had not been identified as a fire risk until the day of the inspection, which meant that this issue and risk remained since November 2022.
- In another location, a door wedge was used to hold open a fire door at times.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs were assessed and care plans were kept under regular review. Annual review meetings were completed and included participation with residents and their representatives, as appropriate. Residents were supported to identify and achieve personal goals for the future.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required supports with behaviour management had support plans in place which included MDT input. Restrictive practices that were identified as being in place were found to be kept under regular review with the MDT and reviewed with the provider's rights committee. However, in one location the following was found;

- One resident's support plan described strategies, including calling the

emergency and other services, to support when a resident engaged in particular behaviours that were of concern; however staff described responding in a different way to what was contained on the support plan.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding concerns in one house were kept under ongoing review since the concerns came to light, and there were ongoing reviews of the compatibility and future living arrangements for residents affected. However the following was found;

- The formal safeguarding plan for one resident was not in place and was not available for staff supporting residents.
- Despite the ongoing reviews of safeguarding concerns and discussions about future living options, one resident spoke about being 'petrified' at times in their home.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While in general residents' rights were promoted with residents consulted about the running of their homes, and they were supported to make choices in their day-to-day lives. However, the following was found in one house;

- One resident's right to privacy was impacted as staff described using a hole in the bedroom door (since an incident whereby the door was broken in November 2022) to look in at the resident when they had concerns about the resident's safety and welfare. Staff said that the resident did not like this, but staff felt it was required due to concerns about the resident's welfare at times. This had not been identified as a human rights issue and therefore had not been reviewed as to what, if any, alternative measure could be used to mitigate the risks that staff described.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Juniper Services OSV-0004696

Inspection ID: MON-0035505

Date of inspection: 04/04/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The training records have now been reviewed to reflect initial and refresher training dates. Any outstanding trainings have now been scheduled for staff and all will be completed by 01/06/2023	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Two team leaders were appointed to the management team for the area to assist with overall governance and management per the compliance plan of July 2021. One of these team leaders who was on leave has now returned to work on the 27/04/23 on a part-time basis and is carrying out all of her supernumerary hours to assist with governance and management of one designated centre. Due to the current labour shortages, it has proven difficult to recruit a temporary replacement for the other team leader's ongoing leave. However, we have now been successful in recruiting another temporary full-time team leader position to assist with governance and management in day services. This post is due to commence by 29/05/2023. This will allow the area manager with person in charge responsibilities for Juniper Services to dedicate additional time for proper oversight of this designated centre.	

A further permanent full-time team manager post (CNM2 grade) is being recruited to further enhance the overall management team in the area. This post is being prioritized for immediate advertisement and an appointment will hopefully be made by 11/09/2023. This will allow the area manager with person in charge responsibilities for Juniper Services designated centre to dedicate additional time for proper oversight of this designated centre.
The area manager will be in a position to visit the designated centre on a weekly basis. These visits have commenced from the 10/04/2023. In addition, audits tools have been reviewed and a new template has been developed to support managers with weekly audits of designated centres. This will support the manager with more effective reviews and better oversight of the centre.
Maintenance work to ensure that the premises were well maintained and hygienic was followed up and addressed immediatly on the day of inspection on the 04/04/2023.
A further deep clean has been scheduled to commence on Monday 22/05/2023 for all the houses in this designated centre.
An IPC audit was completed by the IPC Link Practitioners on all houses in this designated centre on the 16/05/2023 and all recommendations are being followed up on with immediate effect.
A health and safety audit by the Health & Safety Officer was carried out on the 25/05/23 for all houses in this designated centre.
A building contractor had been engaged prior to the inspection to review the water leak and damp issues. This is a staged process to ascertain the cause and the remedial works required. The contractor estimates the shortest time frame for completion is two weeks. However, if it is found to be a more serious problem, it will take a longer timeframe – estimated finish date 30/06/2023.
Audit tools have been reviewed and a refresher training on the completion of audits was carried out by the Quality Enhancement and Training department manager on the 12/05/2023.
Staff are receiving refresher training on the accident and incident reporting system. This will be completed by 06/06/2023.
All risk assessments have been reviewed and updated as required in conjunction with the relevant multidisciplinary professionals. This work will be completed by the 29/05/2023. Staff have also been scheduled to attend refresher risk management training. This will be completed by 01/06/2023.
An environmental risk assessment was completed on the 25/05/2023 by the Health & Safety Officer. This will address any fire safety risks in the event of any property damage in the future.
The statement of purpose was reviewed and updated immediately to include the additional staffing on the day of inspection - 04/04/2023.
All documentation, including the safeguarding plan is now available at the centre from the 04/04/2023.
Any outstanding trainings have now been scheduled for staff and all will be completed by 01/06/2023.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose was reviewed and updated immediately on the day of inspection - 04/04/2023.
The statement of purpose now reflects the changes in the WTE arrangements in the designated centre and the increase in staffing.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All of the actions listed in the report have been / are being addressed.
• The radiator in the kitchen was repaired immediately on the day of the inspection 04/04/2023.
• A building contractor had been engaged prior to the inspection to review the water leak and damp issues. This is a staged process to ascertain the cause and the remedial works required. The contractor estimates the shortest time frame for completion is two weeks. However, if it is found to be a more serious problem, it will take a longer timeframe 30/06/2023
• The fire doors have been repaired - this action was completed on the day of inspection 04/04/2023
• The small nails have been put back in place on the side panel on the stairs – this action was completed immediately on the day of inspection, 04/04/2023.
• The house has been cleaned thoroughly - completed on the 08/04/2023.
• A further deep clean has been scheduled to commence on Monday 22/05/2023 for all the houses in this designated centre.
• An IPC audit was completed by the IPC Link Practitioners on all houses in this designated centre on the 16/05/2023 and all recommendations are being followed up on with immediate effect.
• A health and safety audit was completed by the Health & Safety Officer on the 25/05/23 for all houses in this designated centre.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All fire containment is now in place. These issues were addressed immediately on the

day of inspection, 04/04/2023.
All risk assessments have been reviewed and updated as required in conjunction with the relevant multidisciplinary professionals, 29/05/2023.
Staff have been scheduled to attend refresher risk management training, 01/06/2023.
An environmental risk assessment was completed on the 25/05/2023 by the Health & Safety Officer. This will address any fire safety risks in the event of any property damage in the future.
A new template has been developed to support managers with weekly audits this will support the manager with more effective reviews and oversight. These weekly visits by the manager with person in charge responsibilities, have commenced from the 10/04/2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All fire containment is now in place. These issues were addressed immediately on the day of inspection 04/04/2023.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
While the correct practice was in place and agreed between the Behaviour Support Specialist and the staff team, the reflecting documentation was not available on the day of the inspection. The positive behaviour support plan is now on file to reflect the strategy in place. The manager will now be reviewing the plan and all ancillary documentation on an ongoing basis to ensure that the plan is up to date and that there are no gaps in documentation. These reviews have commenced from the 10/04/2023.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The safeguarding plan in place for one resident has now been confirmed as the formal

safeguarding plan as of the day of inspection, 04/04/2023.

Compatibility assessments have been completed for one person in one house to live in an alternative location. Two trials of alternative accommodation have not been successful. A further compatibility assessment is currently being explored in another alternative location and will be completed by the 30/06/2023. In the interim, additional staffing has been allocated in the current living option to ensure the person supported has individual supports for life choices and activities and is safe at all times. This arrangement ensures minimal interactions between the two people supported with both people having their own separate areas for living and sleeping and freedom of choice.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The issue involving the person's right to privacy in their bedroom has been resolved i.e. the door was repaired on the day of the inspection on the 04/04/2023.
The service provided is rights based and focused on ensuring the will and preference of people while balancing safety issues for people. There has been follow up with staff by management with further training now planned 01/06/2023.
In the context of supporting people in very a complex situation there is ongoing discussion on this balance with management and the MDT. With the enhanced governance structure, staff will receive more support and focused guidance to ensure that a rights based approach is in place at all times. The area manager will be in a position to visit the designated centre on a weekly basis. A new template has been developed to support managers with weekly audits; this will support the manager with more effective reviews and oversight. These visits have commenced from the 10/04/23.

Staff in this service have been scheduled for refresher training in rights protection and promotion and restrictive practices on 01/06/2023. The organisation has had a human rights review committee in place since 2007. All restrictive practices are to be referred to this independent committee for due process. This procedure has been reiterated with staff.
With the recent enactment of the Assisted Decision Making (Capacity) Act, there will be further training in the area of rights protection and promotion, restrictive practices and capacity building for all people supported and staff throughout the year commencing on the 01/06/2023.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	01/06/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	22/05/2023
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	29/05/2023

	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.			
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	12/05/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	04/04/2023
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	04/04/2023
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	04/04/2023
Regulation 07(1)	The person in charge shall	Substantially Compliant	Yellow	04/04/2023

	ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	04/04/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	01/06/2023