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:	Belltree
Name of provider:	Resilience Healthcare Limited
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	25 April 2022
Centre ID:	OSV-0005635
Fieldwork ID:	MON-0036801

About the designated centre

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

This designated centre is located in a mature residential area on the outskirts of the city. The premises is a two-storey detached house where residents have access to a choice of sitting rooms, a kitchen and dining area, utility room and, their own bedroom. Two of these bedrooms have en-suite facilities. There is a pleasant garden and paved area to the rear of the property. A residential service is provided and residents have access to an external day service or, receive an integrated type service from their home. A maximum of four residents can be accommodated. The designated centre is open seven days a week and the model of support is social. The house is always staffed and there are a minimum of two staff members on duty at all times. The management and oversight of the service is delegated to the person in charge supported by a team leader.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Monday 25 April 2022	09:45hrs to 17:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This unannounced inspection was undertaken to follow-up on the findings of the last HIQA (Health Information and Quality Authority) inspection of this centre (completed in October 2021) and in response to a trend in notifications submitted to HIQA by the provider. The inspector found the provider had responded to the incidents notified to HIQA. However, better evidence was needed as to how the provider was assured the individual and collective needs of this cohort of residents were compatible and conducive to the provision of a safe quality service and a good quality of life.

While acknowledging the providers response to the incidents and events that had occurred, the overall inspection findings were not reflective of a service that was governed and managed to ensure that the service provided was safe, appropriate to residents' needs, consistently and effectively managed. For example, actions that had issued at the time of the last HIQA inspection were not satisfactorily resolved and were reissued. As part of its own quality assurance systems the provider had not completed an unannounced internal review of the service since the one last completed in very early August 2021.

On arrival at the centre the inspector saw that all staff on duty were not adhering to controls designed to reduce the risk of the introduction and spread of COVID-19. All staff were not wearing the requiring FFP2 mask and controls applicable to others such as contractors were also not consistently implemented. The house was busy with repair and refurbishment works being completed to the premises. These works introduced risk to resident and staff safety and there were no evident controls. These works had not been risk assessed so that controls to manage the risk were identified and put in place.

There were two vacant staff posts and an ongoing reliance on relief and agency staff. The provider did not demonstrate how arrangements such as confirming the completion of mandatory and required training and familiarisation with the centre specific fire evacuation procedures were adapted to suit these staffing arrangements. The planned staffing levels were not in place on the day of inspection.

A fourth resident had been admitted to the centre since the last HIQA inspection. Three residents received an integrated type service where their day programme of activities and community engagement was delivered from the centre. One resident attended on off-site day service. Over the course of the day the inspector had the opportunity to meet and engage with all four residents. The inspector observed how residents spent their day, how they interacted with each other and with the staff team on duty. Residents were relaxed with the presence of the inspector in their home and chatted easily with the inspector. Residents were curious about the work of the inspector, eager to establish how long the inspector was going to be in the house but happy for the inspector to be in their home. The inspector noted the

individualised routines of the house and the respect for the individuality of each resident. There was an easy rapport between residents and staff as they went about the normal routines of the day such as attending to personal care, planning and preparing meals and leaving the house to engage in community based activities. Residents were given choice and were seen to make their own decisions.

Residents discussed a recent trip they had enjoyed together to a local folk park and there was much excitement about an upcoming trip to a concert. One resident showed the inspector a photo of them attending a recent sporting event with a peer. The resident confirmed that they both got on "like a house on fire" and had really enjoyed the match as their team had won. There was some discussion of family and of COVID-19. For example, one resident was hoping to have the opportunity to go on a pilgrimage to Lourdes again now that restrictions had eased.

Residents did not raise any specific concerns or worries with the inspector. However, the notifications submitted to HIQA (as mentioned above) had clearly reflected an intense period where the individual needs of residents had impacted on them but also on their peers and on the quality and safety of the service. A staff spoken with told the inspector that plans and strategies put in place were working. There was evidence to support this for example, in the notifications submitted to HIQA. However, the inspector did observe one brief interaction between residents that indicated a level of risk and fear. This resolved quickly and was brought to the attention of management. The house was busy and noise levels were heightened at times. Ultimately, the provider needed to demonstrate and provide explicit assurance that this cohort of residents were compatible to live safely and well together in this shared living arrangement.

In summary, there was evidence that this was a person-centred service and the provider had taken action to protect residents from harm including harm from a peer. However, there were repeat failings and overall the provider did not demonstrate a satisfactorily improved level of compliance with the regulations.

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

Capacity and capability

There were governance and management systems in place. Roles, responsibilities and reporting relationships were understood. For example, the team leader confirmed they had access as needed and good support from the recently appointed person in charge. The person in charge was on planned leave the day of this inspection. A manager deployed to the centre to support the process of this inspection confirmed there were formal monthly meetings between local and senior management teams. The provider also continued to operate weekly COVID-19

meetings attended by local, senior and risk management teams. However, based on these inspection findings the provider did not adequately demonstrate how it's governance and management arrangements ensured and assured consistent and effective oversight of the quality and safety of the service and, brought about effective improvement.

For example, as discussed in the opening section of this report management and oversight did not ensure that staff consistently adhered to controls put in place by the provider to protect residents and staff from the risk of COVID-19 and other respiratory illness. The process of identifying and managing risks was not always used in a purposeful and dynamic way to meaningfully respond to changes and circumstances in the service. Given the findings of the previous internal review and the findings of the last HIQA inspection, it was of concern to the inspector that the provider had not completed (as required by the regulations at least every six-months) a further unannounced review of the quality and safety of the service since the one last completed in August 2021.

The inspector saw that a health and safety specific audit had been completed on the 25 March 2022. The provider also operated a system for tracking the progress of actions needed for improvement that had issued internally and externally such as from HIQA. However, the failure to complete a timely follow-up unannounced review did not provide assurance as to how the provider verified and assured itself of the satisfactory progression of quality improvement plans. These HIQA inspection findings would indicate that actions had not been progressed as reported on the internal tracking system. This HIQA inspection also found actions were not addressed further to the internal health and safety audit such as the dismantling of self-closing devices on fire-resistant doors.

The report of the annual review of the quality and safety of the service was on file. However, the report seen did not include details as to how and if residents and their representatives had been consulted with and what feedback they had provided.

The inspector saw from the staff rota and the team leader confirmed there were vacant full-time staff posts. This meant there was ongoing reliance on both relief and agency staff. There were shifts that had to be filled by relief and agency staff when the staff rota was prepared. The inspector saw regular changes were made to each planned staff rota. The planned staffing levels were not maintained on the day of the inspection due to an unplanned staff absence.

The inspector saw that the planning of the staff rota did consider the need to provide residents with continuity and consistency. Based on the sample of rotas seen the same relief staff and a regular cohort of agency staff was used. However, the provider did not have effective systems in place that reflected these staffing arrangements. For example, while it was again confirmed for the inspector that there were agreed procedures for confirming agency staff had completed mandatory and required training, the required documentary evidence of training was in place for only one of four agency staff that regularly worked in the centre.

The inspector saw that there was a planned schedule of staff training. The team

leader also confirmed that in-house fire safety training for staff was imminent and would include regular, relief and agency staff. However, in addition to the failure to verify the training completed by agency staff, the staff training matrix indicated further training deficits. For example, one of the three relief staff members listed on the staff rota was not included in the matrix. Based on the records seen refresher training for staff was overdue including training in manual handling, responding to behaviour of risk, safeguarding, the management of medicines, fire safety and infection prevention and control. It was not adequately evidenced if all planned training had been completed as scheduled.

Regulation 15: Staffing

The staff rota indicated continuity and consistency for residents was considered. However, there were vacancies and ongoing reliance on both relief and agency staff. The inspector saw regular changes were made to each planned staff rota. The planned staffing levels were not maintained on the day of the inspection due to an unplanned staff absence.

Judgment: Substantially compliant

Regulation 16: Training and staff development

In addition to the repeat failure to verify the training completed by agency staff, the staff training matrix indicated further training deficits. For example, one of the three relief staff members listed on the staff rota was not included in the matrix. Based on the records seen refresher training for staff was overdue including training in manual handling, responding to behaviour of risk, safeguarding, the management of medicines, fire safety and infection prevention and control. It was not adequately evidenced if all planned training had been completed as scheduled.

Judgment: Not compliant

Regulation 23: Governance and management

Based on what the inspector observed, read and discussed the provider did not adequately demonstrate how it's governance and management arrangements ensured and assured consistent and effective oversight of the quality and safety of the service and effectively brought about improvement. Given the findings of the previous internal review and the findings of the last HIQA inspection, it was of concern to the inspector that the provider had not completed (as required by the

regulations at least every six-months) a further unannounced review of the quality and safety of the service since the one last completed in August 2021. This did not provide assurance as to how the provider verified and assured itself of the satisfactory progression of quality improvement plans. These HIQA inspection findings would indicate that actions had not been progressed as reported on the internal tracking system. While an annual review of the quality and safety of the service had been completed the report did not demonstrate how and if residents and their representatives had been consulted with and what feedback they had provided.

Judgment: Not compliant

Quality and safety

There was evidence that this was a person centred service where the individuality, choices and decisions of residents were respected and promoted. The inspector found the provider had responded to matters that had arisen amongst this cohort of residents and the actions taken by the provider to safeguard residents were potentially starting to have a positive impact. However, while residents did get on well together on many levels, the provider needed to put an explicit process in place to demonstrate and provide assurance that this cohort of residents could live together safely and happily.

At the time of the last HIQA inspection the inspector found that residents had a good relationship with each other on many levels. However, there was also emerging evidence at that time that residents may have had needs that were not compatible in a shared living arrangement. Since the last HIQA inspection a fourth resident had been admitted to the centre. Since that last HIQA inspection and particularly in the first quarter of 2022 the provider had reported to HIQA a number of incidents where the individual needs of residents and the use of behaviour to communicate those needs had impacted negatively on their peers. All four residents were impacted at different times and in different ways. Some incidents were brief while others were prolonged and greatly upset the dynamic of the house and caused much anxiety amongst residents.

In response to these incidents the inspector saw that residents and the staff team had regular support and input from the provider's behaviour support team. The inspector saw that a range of tools were used to communicate with residents to explore their feelings and anxieties and to support them to better manage these. The inspector saw a very comprehensive but also very simple resident and centre specific crisis management plan. The plan set out for staff the individualised response to be used with each resident to prevent escalation of their anxieties and behaviours. The team leader confirmed this guidance had been brought to the attention of all staff. The team leader confirmed there had been no further incident since that last reported to HIQA. This indicated that the crisis management plan was

being followed and was having an impact. The team leader had good knowledge of each resident and described factors peculiar to each resident and how these could impact on their overall well-being and trigger behaviours. The strategies outlined in the crisis management plan were therapeutic in their response.

However, the inspector did note a very brief encounter between two residents that was triggered by a misunderstanding of something that was said. While brief, there was, based on what the inspector observed, a element of anger displayed and one resident visibly physically pulled back from their peer. The inspector also noted a level of residual anxiety in one resident spoken with. The house was busy and noisy at times not in an unpleasant way but in a way that could cause annoyance and disturbance to others. There was a pattern to the notifications submitted to HIQA where the actions of one resident though not specifically directed at peers had impacted on their peers and possibly resulted in reactive behaviours in response. However, while there may have been some preliminary discussion there was no explicit evidence available to the inspector that the provider had considered the long-term compatibility of this cohort of residents. Assurance was needed that the provider had in this designated centre the arrangements needed for all four residents to live safely together in such close proximity and in a way that consistently promoted and protected each residents overall health and well-being.

There was a safeguarding dimension to these incidents. There were other safeguarding matters arising in the house such as other high risk behaviours and allegations of abuse made by residents. The inspector saw reports and safeguarding plans that had been submitted to the local safeguarding and protection team for each of the four residents. The team leader confirmed the safeguarding and protection team had paid a recent visit to the house. The team was reported to be satisfied with the safeguarding measures put in place by the provider. This was also evident from records seen by the inspector. There was evidence of the measures outlined in the safeguarding plans such as the regular input from the behaviour support team and the use of social-emotional learning skills programmes with residents.

Based on the notifications that had been submitted to HIQA there had been failings in the initial response to an allegation made by a resident. The team leader described the action taken to address this failing. The crisis management plan mentioned above set out for staff very clear safeguarding guidance on how to record and report any allegations made by a resident. One stated safeguarding action was the completion by staff of regular refresher safeguarding training. However, the completion of baseline and regular refresher safeguarding training and the regularity of that training was not robustly demonstrated in training records.

There was a centralised COVID-19 response group that was still available to all services and met weekly. The premises did present as visibly clean and staff were seen for example, to clean the bathroom between its use by different residents. Prominent signage was in place in relation to the wearing of a face mask. However, while there was a range of audit tools in use observations on the day of inspection indicated there was inadequate oversight and direction on adherence to infection prevention and control measures. This increased the risk of the accidental

introduction of and the onward transmission of infection. Two staff on duty were not wearing a face mask in circumstances where one was required and as set in the centre's risk assessments. This was addressed immediately once queried by the inspector. The day after this HIQA inspection the person in charge confirmed that the requirements and circumstances for the wearing of an FFP2 mask had been clarified for all staff.

Other than in the staff office products for sanitising hands were not visible in other areas of the house, for example at the entrance for visitors. This was seen to be addressed as the inspection progressed. The team leader advised the inspector that access to these products was restricted due to a risk that presented to one resident. This risk and controls that ensured resident safety but also availability of the product to others such as visitors and contractors were not explicitly set out in a risk assessment. The bin for staff to dispose of used face masks was not suitable. This was addressed by the team leader once highlighted by the inspector. The inspector saw that infection prevention controls to be implemented so that maintenance and refurbishment work in the centre could be safely undertaken were not consistently followed.

Premises works were underway on the day of inspection. The main bathroom on the first floor was not operational due to a leak. This meant that three of the four residents and the staff team were all currently using the ground floor bathroom. The ground floor bathroom ordinarily operated as an ensuite facility for one resident. However, there was no privacy lock on the door between the bathroom and the resident's bedroom. At verbal feedback of the inspection findings the inspector requested robust oversight of the bathroom refurbishment so that the work was progressed as speedily as possible.

While some improvement was noted better oversight of the centre's fire safety arrangements was needed. For example, the displayed diagrammatic evacuation plan was very small and escape routes were not easily identified from it. The displayed evacuation procedures did not give very clear stepped guidance on the procedure to be followed. Two devices designed to hold open and close fire-resistant doors were seen to be disconnected throughout the day and the door to the staff office was held open by a box of paperwork when the inspector arrived. Each resident had a personal emergency evacuation plan (PEEP) but one PEEP had not been updated to reflect the possibility that a resident may not co-operate with a request to evacuate as had happened during a recent simulated drill. The records of the simulated drills were improved and highlighted any challenges that had arisen. The drills simulated different evacuation scenarios including testing the ability of two staff to evacuate all four residents. However, based on these records approximately half of the staff team had yet to participate in a simulated drill. The team leader said that these staff had been identified. However, the simulated drills needed to be formally scheduled to ensure that these staff participated in them.

Some minimal improvement was noted in the assessment and monitoring of risks and the provider had responded to the increased risk to resident safety and quality of life that had recently arisen in the centre. However, there was poor correlation between the general register of risks and risks as they pertained to each resident.

Some residual risk ratings were still low particularly given the recent incidents and the risk for incidents occurring. For example, the general risk rating for the risk of abuse was green as was a risk assessment for living with others. The inspector again found that controls that would have supported the low residual risk ratings were not in place such as the wearing of FFP2 masks, controls for visitors such as contractors and correctly functioning self-closing devices. The assessment of risk was not dynamic. For example, there was no risk assessment and no evident controls to ensure safe access to the first floor for residents and staff during the premises works. This work created a risk for falls including the risk of a fall on the stairs due to trailing cables on the landing and the fact that the attic stairs was pulled down onto the landing. Having noted this on arrival the inspector highlighted both the risk and the need for controls including resident supervision. There was no risk assessment for the closure of the main bathroom and the increased dependence on the ground floor facility. For example, the increased risk for contamination and cross-infection and the need for enhanced controls.

Regulation 17: Premises

The main bathroom on the first floor was not operational due to a leak. This meant that three residents and the staff team were all currently using the ground floor bathroom. There was no privacy lock on the door between the bathroom and a resident's bedroom. At verbal feedback of the inspection findings the inspector requested robust oversight of the bathroom refurbishment so that the work was progressed as speedily as possible.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There was poor correlation between the general register of risks and risks as they pertained to each resident. Some residual risk ratings were still low particularly given the recent incidents and the risk for incidents occurring. For example, the general risk rating for the risk of abuse was green as was a risk assessment for living with others. The inspector again found that controls that would have supported the low residual risk ratings were not in place. The assessment of risk was not dynamic. There was no risk assessment and no evident controls to ensure safe access to the first floor for residents and staff during the premises works. There was no risk assessment for the closure of the main bathroom for example, the increased risk for contamination and cross-infection.

Judgment: Not compliant

Regulation 27: Protection against infection

While failings identified by the inspector were addressed once highlighted the inspectors observations on the day of inspection indicated there was inadequate oversight and direction on adherence to infection prevention and control measures. This increased the risk of the accidental introduction of and the onward transmission of infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While some improvement was noted better oversight of the centre's fire safety arrangements was needed. The displayed diagrammatic evacuation plan was very small and escape routes were not easily identified from it. The displayed evacuation procedures did not give very clear stepped guidance on the procedure to be followed. Two devices designed to hold open and close fire-resistant doors were seen to be disconnected throughout the day and the door to the staff office was held open by a box of paperwork when the inspector arrived. One PEEP had not been updated to reflect the possibility that a resident may not co-operate with a request to evacuate as had happened during a recent simulated drills. Based on records see a number of staff had yet to participate in a simulated drill. The team leader said these staff had been identified and fire safety training for all staff was imminent. However, the simulated drills needed to be formally scheduled to ensure these staff participated in a drill.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was a pattern to the incidents notified to HIQA. Assurance was needed that the provider had in this designated centre the arrangements needed for this cohort of residents to live safely together in such close proximity and in a way that consistently promoted and protected each resident's overall health and well-being.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents and the staff team had regular access to and support from the providers behaviour support team. A range of communication tools sought to assist and support residents to better manage their concerns and anxieties. Staff had been provided with a comprehensive crisis management plan. The response to behaviour of concern and risk was therapeutic other than when restrictions were deemed necessary as a last resort for the safety of the resident and others.

Judgment: Compliant

Regulation 8: Protection

The provider had responded to safeguarding concerns that had arisen in the centre. The provider had fulfilled its reporting obligations and had put measures in place to protect residents. However, one stated safeguarding action was the completion by staff of regular refresher safeguarding training. However, the completion of baseline and regular refresher safeguarding training and the regularity of that training for all staff was not robustly evidenced in the training records.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Belltree OSV-0005635

Inspection ID: MON-0036801

Date of inspection: 25/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Beltree House will recruit five full time staff members before close of July 2022. This will ensure consistency and adequate support for Service Users and the team. Each newly recruited team member will receive full induction prior to introduction to the service. Their training needs will be analyzed and each individual will be enrolled for any outstanding training. Mandatory training will be in place before introduction to the service users. All records will be stored and available on site. It is a target to reduce the use of agency staff to sick and annual leave cover only. It is anticipated that this approach will be measurable and evidenced with less changes in the roster for Q3 & 4 in 2022. Fire Evacuation procedures will be prioritized during induction. An improved induction and fire evacuation procedure will be implemented in May 2022- this will see a sign off on all staff within the house being inducted to fire evacuation plans, PEEPS, fire fighting equipment location, fire assembly location and checking certification on entry shift to house. Analysis of the schedule for the week and staffing levels will be reviewed to ensure planned staffing levels are consistently met as per required standards. Group, peer and crisis response supervision sessions will be maintained regularly.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and	

staff development:
All training needs will be met by the 15th June. Existing staff will be scheduled for outstanding needs- in particular manual handling, responding to behavior of risk, safeguarding, the management of medicines, fire safety, and infection prevention and control. If it is an agency staff member,compliance file from the agency will be requested before a staff commences. Commitment to remove the reliance on agency except for unplanned cover.
The training matrix will be fully reviewed to include all staff (contracted and agency), all mandatory trainings, including refreshers, and schedule of upcoming needs.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulatory Provider Inspections are a priority, and the missed timeliness with this one is a recognized inadequacy. Unannounced Provider Inspection will occur in Q2 of 2022. Actions from this audit will also feed the residential improvements in practice.

As observed during the inspection, was that the process of identifying and managing risks through the risk management register was not as dynamic as it needs to be- it is understood that there should have been a direct correlation between the incidents leading to Safeguarding, and the practice and responses evidenced. While the risk management plan was acknowledged as satisfactory, the consistency across the governing documentation was not adequate- this will be addressed immediately, and the quality and continuity of evidence will be seen across all documentation.

The measures in place to support the safe delivery of bathroom enhancements was not strong. Protocols supporting planning and safe delivery of these enhancements will be implemented. The relationship of this enhancement to contamination risk and IPC is recognized and additional steps will be in place in May 2022 to support a safe transition to the completed works.

Feedback collection for service users before June 15th. Request further feedback from support persons/ family- end Q2 2022.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

We are currently enhancing the service users environment in upgrading their bathroom facilities. Completion of current bathroom works will be finalized by June 2022, and measures in place to support shared use of downstairs bathroom, will cease. The shared measures have been increased since the inspection by increasing cleaning, and contractor and staff protocols for safety have been implemented.
Additional Cleaning Schedule for cleans between use daily- given number of users- has been implemented immediately.
A privacy lock for the door adjoining between a bedroom and the bathroom is scheduled.
Protocols for staff and contractor information and understanding are in place.

There will be an exploration from management for improvements and enhancements which are being reviewed; Three particular areas of focus are;
Sound
Privacy
Ability for individuals to move away from incidents if they occur.

OT consultation will be a feature of this, and the decisions will be finalized by July 2022.
Additional work from the suggestions which will emerge will be completed by Q4 2022.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
As observed during the inspection, was that the process of identifying and managing risks through the risk management register was not as dynamic as it needs to be- it is understood that there should have been a direct correlation between the incidents leading to Safeguarding, and the practice and responses evidenced. While the risk management plan was acknowledged as satisfactory, the consistency across the governing documentation was not adequate- this will be addressed immediately, and the quality and continuity of evidence will be seen across all documentation- incident reports- risk registers- restrictions that may be required- schedules and audits.

Eliminate bad practice related to holding doors open, through reinforced messaging and mentoring from Seniors and also team and supervision agendas. The OHS representative will also focus on priority safety points within each team meeting.

Secure feedback opportunity with all Service Users by June 2022.

Update all Service User's PEEPS by May 30th.

Simulated Fire Drill for all staff by May 30th.

High standard of induction for all staff members, including fire procedure, evidenced in

their staff files.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
All staff have been advised and reminded of the ongoing requirements for a service in relation to mask wearing- FFP2's irrespective of public advice outside of work settings. This will be reinforced by not only the Service Manager, but also the Team Leader and Senior Support Workers, to ensure no complications or weaking of precautions.

Driving improvements related to continuous development around cleaning schedules and identifying new practices which support best practice. Introduce Resilience national cleaning schedule template- June 2022.

Monthly Team Meetings and supervision to include IPC as an ongoing agenda item, and seniors, team leaders and manager to ensure adherence with same. Monitor and address any complacency with direct conversations at the time.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All team members have received fire safety training and are certified. All team members have participated in a fire drill, and have been inducted to emergency evacuation procedures.

High standard of induction for all staff members, including fire procedure.

Diagrammatic Evacuation Plan- to be enlarged and improved- immediately.

Automatic magnetic Door Closures to be affixed to two doors causing concern. Sourcing a local provider to address at earliest opportunity. June 2022

Update Peep for all service users- May 2022.

Simulated Drills to include all staff members June 2022

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
To demonstrate and provide explicit assurance that this cohort of residents are compatible to live safely and well together in this shared living arrangement, the service manager will undertake compatability risk assessments and ensure that the pattern of incidents demonstrates a decline in those associated to recent NFO's. July 2022.

The team will focus on maintaining and growing the positive strengths identified within the report, associated to excellent practice in individualised routines and respect for choice which is currently evident. The easy rapport and positive sides of service users relationships will be nurtured, but ensuring one on one time and activities with peers outside of their home environment are regular and growing in frequency.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Long term compatibility for cohort will be assessed to live safely and in close proximity to each other.

Promote and protect each resident's overall wellbeing, ensuring minimal impact from behaviors and incidents on each other. The compatibility risk assessing and the exploration as to environmental improvements will support this. Also consideration will be applied to the outcomes of their feedback surveys and a commitment to address any issues which may arise.

Safeguarding- decline in the recent peak in notifications- reduction by 50%. August 2022.
Close and supportive working relationship with safeguarding team. Ongoing

Response to Allegation- refresher SOVA training

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/06/2022
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	30/06/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/06/2022

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	31/07/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided	Not Compliant	Orange	15/06/2022

	in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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	31/07/2022
Regulation 27	The registered provider shall ensure that 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.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means	Substantially Compliant	Yellow	30/06/2022

	of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/07/2022
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	30/06/2022