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:	Ohana
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	07 October 2021
Centre ID:	OSV-0007781
Fieldwork ID:	MON-0029343

About the designated centre

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

Ohana is a designated centre for two residents, over the age of 18 years, who receive a service from Saint Patrick's Centre Kilkenny. The provider describes the aim of the service "To provide intentional supports for People with disabilities; enabling them to live full and inclusive lives by contributing and enriching the fabric of their local communities." The centre operates all year round and staffing is provided day and night to meet support the needs of the residents. The centre affords high supports in two apartments with the support of a person in charge, nurse, social care worker and health care assistants on duty throughout the day.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 October 2021	09:00hrs to 17:00hrs	Leslie Alcock	Lead

What residents told us and what inspectors observed

This was a short term announced inspection completed to assess the centre's ongoing compliance with regulations and standards. The inspection took place during the COVID-19 pandemic and therefore recommended infection control measures were taken by the inspector and staff to ensure adherence to COVID-19 guidance for residential care facilities. This included the wearing of personal protective equipment (PPE) and maintaining a two metre distance at all times during the inspection day.

The designated centre comprises two single occupancy apartments next to each other in a residential area of a small town. Each apartment had a well maintained garden. In each apartment there was suitable sensory equipment available for the residents in different areas. In addition to this, each resident had a sensory room designed and laid out to meet their individual needs and interests.

The inspector spoke with the residents to determine their views of the service, observed where they lived, observed care practices, spoke with staff and reviewed the resident's documentation. This information was used to gain a sense of what it was like to live in the centre. On arrival, the inspector met one resident who was having their breakfast. This resident showed the inspector around their home ensuring the inspector saw each room in their apartment including the garden. The resident was observed engaging with some of the sensory equipment on the walls in the hall and the living room as they moved around their home. The inspector later met the second resident who allowed the inspector to see their bedroom and music and sensory room but chose not to engage with the inspector.

In general, the inspector found that the residents appeared content, relaxed and comfortable living in the centre. They were supported throughout the day by their support staff. The residents appeared comfortable in the company of staff and in their environment. The residents enjoyed personalised activation schedules. On the day of the inspection, the residents went for a walk, a swim, and one resident had an appointment with their general practitioner (GP).

The inspector observed respectful, warm and meaningful interactions between staff and the residents during the day. Staff spoken with on the day of inspection, spoke of the residents in a professional manner and were keenly aware of their needs. Staff were observed reading and adhering to guidelines and recommendations within individualised personal plans to support the residents to achieve a good quality of life.

In summary, based on what the residents and staff communicated with the inspectors and what was observed, it was evident that the residents received overall good quality care and support. The next two sections of this report outline the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being

delivered. Some improvements were required to promote higher levels of compliance with the regulations to ensure a safe and quality service was provided at all times. This was observed in areas such as; governance and management and fire safety.

Capacity and capability

Overall, the inspector found that the registered provider demonstrated the capacity and capability to support the residents in the designated centre. While there were management systems in place to monitor the quality and safety of the care and support delivered to the residents, these required further review to ensure effective oversight of the centre as outlined below.

The centre had a clearly defined management structure in place consisting of a person in charge, who worked on a full-time basis with responsibility for two centres. The person in charge was supported by the staff team and a community services manager. The community services manager demonstrated good knowledge of the residents and their needs and had a regular presence in the centre. The person in charge was found to be competent, with appropriate qualifications and experience to manage the designated centre. This individual also demonstrated good knowledge of the residents and their support needs. However, some improvement was required in relation to their oversight of the service provided in the centre.

The annual review for the previous year and six-monthly provider unannounced audits were occurring in line with the requirements of the regulations and where improvements were identified, for the most part, plans were in place to address these. However, some identified issues had not been rectified. For example, the annual review identified an issue with a fire door and there was no record nor was it communicated whether this action had been completed. A similar issue was identified by the inspector on the day of the inspection.

Overall, the staff team were found to have the skills, qualifications, and experience to meet the assessed needs of the residents. There were some staff vacancies and where cover was required, it was found that a small number of regular agency staff were used. This ensured consistency of care for the residents.

All staff were in receipt of support and supervision provided by the person in charge however this was not taking place at intervals that were in line with the provider's policy. Mandatory staff training and refresher training was facilitated by the provider. However, not all training and refresher training was up-to-date for staff. The provider had scheduled dates in place for the completion of same.

Regulation 15: Staffing

There was a planned and actual staff rota in place and it was reflective of the staff on duty on the day of the inspection. There was an appropriate skill mix and numbers of staff to meet the assessed needs of residents. The staff were knowledgeable about how to meet the residents needs and were seen to interact with the residents in a warm, respectful and dignified manner. Nursing care was also available when required. The provider ensured continuity of care through the use of an established staff team and a small group of regular agency staff where required. A sample of personnel files were reviewed and they contained all the required documentation as per regulation.

Judgment: Compliant

Regulation 16: Training and staff development

The staff were supported and facilitated to access appropriate training including refresher training that was in line with the residents' needs. The inspector viewed evidence of mandatory and centre specific training records. All mandatory training was in place with a small number of staff requiring updated refresher training. The provider had scheduled dates in place for the completion of same. A training department was in place to ensure staff were notified of any upcoming training or refresher training needed.

A comprehensive staff induction programme was provided to new staff which involved training prior to starting in the centre and shadowing experienced staff. Supervision records reviewed and discussions with the person in charge highlighted that one to one formal supervision had taken place for all but one staff member. This supervision meeting was scheduled for the week of the inspection. However, supervision was not taking place at intervals in line with the providers own policy. The provider's policy states that supervision should occur minimally once per quarter. Upon review of a sample of supervision records, formal supervision had not occurred once per quarter. This was not in line with the stated policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider ensured there was a clearly defined governance structure within the centre which ensured that residents received a service which met their assessed needs. While there were management systems in place to monitor the quality and safety of the care and support delivered to the residents, this required

further review to ensure more effective oversight of the centre. There was a full-time person in charge, who was supported by the staff team and a community services manager. The person in charge had responsibility for two centres and based themselves primarily in another designated centre. For the most part, they provided support to the staff team and residents remotely. However, they would attend the centre when required. At times, the person in charge didn't have consistent oversight of the centre. They delegated responsibilities among the staff team but there was no oversight system in place to ensure the delegated responsibilities such as daily fire checks were being conducted correctly as outlined later in the report. Similarly, there were annual audits in place for finance and fire safety but monthly audit records such as vehicle audits provided on the day of the inspection were not kept up to date along with gaps in monthly hygiene audits, finance audits and team leader audits.

The inspector found that while regular management meetings took place, staff supervision and team meetings had not occurred at intervals in line with the provider's policy. The annual review for the previous year and six-monthly provider unannounced audits were occurring in line with the requirements of the regulations and where improvements were identified, for the most part, plans were in place to address these. However, the annual review identified a fire safety issue and it was not clear on the day of the inspection if this issue was rectified in a timely manner.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Contracts for the provision of services were in place for each resident and updated recently. However, these contracts were not signed by the residents or their representatives and there was no record of engagement with the residents' representatives. Easy to read service agreements were also in place with a record indicating an attempt was made to read it to the residents' but they had not appeared to engage with the process.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The current version of the statement of purpose was reviewed and it accurately described the nature of the service provided. The statement of purpose contained all of the information as required by the regulations and there was evidence that it was regularly reviewed.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of restrictive practice records and the designated centre adverse events register took place. This review indicated that quarterly notifications in relation to restrictive practices used in the centre from the last quarter were not submitted to the office of the chief inspector as required.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the centre provided a comfortable home and person centred care to the residents. The management systems in place ensured the service, for the most part, provided appropriate care and support to the residents. However, there were some improvements required in relation to protection against infection and fire safety.

The inspector reviewed residents' personal care plans and they had an up-to-date assessment of need which appropriately identified residents health, personal and social care needs. The assessments informed the residents personal support plans which were up-to-date and suitably guided the staff team. The residents had an annual review called a 'visioning' meeting where the residents interests, likes, skills, talents, and their health and well-being were reviewed.

Overall, the designated centre was decorated in a homely manner. The residents individual apartments were decorated in line with their preferences and pictures of the residents were located throughout the centre.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. Risks were managed and reviewed through a centre specific risk register and individual risk assessments. The risk register outlined the controls in place to mitigate the risks. The centre had suitable fire safety equipment in place, including emergency lighting, detection systems and fire extinguishers which were serviced as required. The residents had personal emergency evacuation plans (PEEP) in place which guided the staff team in supporting the residents to evacuate. There was evidence of regular fire evacuation drills taking place. However, a number of containment measures in place required review as they did not ensure adequate containment in the event of a fire. The registered provider promptly addressed this issue on the day of the inspection. However, the inspector reviewed a sample of the daily fire checks and found that the doors were checked and signed off by staff as operating as required both on the

day of the inspection and in the days leading up to it when the inspector found a number of doors were not closing properly.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing. Personal protective equipment (PPE), including hand sanitizers and masks, were available and were observed in use in the centre on the day of the inspection. However, the hand washing facilities required review as there were no facilities available for residents, staff and visitors to dry their hands appropriately in either apartment. Mechanisms were in place to monitor staff and residents for any signs of infection. However, the inspector reviewed a sample of these records and noted a number of gaps in the recording of staff temperature checks on the week of the inspection.

The provider ensured that residents' had behavioural support plans were in place and that staff had up to date knowledge and skills to respond to and support residents to manage their behaviour. Where restrictions were in place, they were implemented in line with best practice and efforts were made to ensure that the least restrictive method was employed. There was a restrictive practice register in place which was reviewed regularly providing a clear rationale for the use of restrictive practices used however, a number of restrictive practices were not identified such as the locked press used for resident finances and chemicals.

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs of residents; it presented as a warm and homely environment decorated in accordance with the residents' personal needs and interests. The designated centre comprised of two single occupancy apartments in a residential area in a small town. Each apartment had a well maintained garden with suitable sensory equipment available for the residents to utilise. Similarly, each resident had a sensory room designed and laid out to meet their individual needs and interests. The provider had ensured the provision of all requirements set out in Schedule 6 including adequate storage, and adequate social, recreational spaces as well as kitchen, bathroom and dining facilities.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had detailed risk assessments and management plans in place which promoted safety of residents and were subject to regular review. There was an up

to date risk register for the centre and individualised risk assessments in place which were also updated regularly. There was an effective system in place for recording incidents and accidents which included an incident analysis that recorded actions taken and whether the action taken was effective and if further action was required and by whom. This system also ensured management had oversight of all adverse events.

Judgment: Compliant

Regulation 27: Protection against infection

The provider and person in charge had taken steps in relation to infection prevention and control in preparation for a possible outbreak of COVID-19. The person in charge ensured regular cleaning of the premises, sufficient personal protective equipment was available at all times and staff had adequate access to hand sanitising gels. Risks associated with residents and staff contracting COVID-19 had been carefully considered and risk assessed with appropriate control measures were in place. An up to date COVID-19 preparedness and service planning response plan was also in place.

However, the hand washing facilities required review as there were no facilities available for residents, staff and visitors to dry their hands appropriately in either apartment. The inspector also observed used towels belonging to a resident stored on a bin beside the sink in one bathroom. Mechanisms were in place to monitor staff and residents for any signs of infection. However, the inspector reviewed a sample of these records and noted a number of gaps in the recording of staff temperature checks on the week of the inspection.

While there was a cleaning schedule in place that included deep cleaning of all aspects of the designated centre to include kitchen appliances and cupboards in the premises. There was no oversight system in place to ensure that these areas had been fully cleaned as visible dirt was observed in some of the cupboards in the kitchen on the day of inspection. Similarly, while the bathroom was on the cleaning schedule it did not specify if certain equipment in the bathroom was included. While it appeared clean on the day of the inspection, it was unclear from the cleaning schedule when that equipment was last cleaned.

Judgment: Not compliant

Regulation 28: Fire precautions

In general, fire safety systems were in place which included personal daily checks that involved a visual check on the fire fighting equipment, containment measures,

emergency lighting and evacuation routes. Fire detection and containment measures were in place in this centre including, fire doors, fire fighting equipment and an appropriate fire alarm system. An issue regarding the effectiveness of a number of fire doors was noted on the day of inspection and this was promptly followed up with maintenance who fixed all the doors to ensure all appropriate containment measures were fully in place at the close of the inspection day. However, the overall system used to monitor the effectiveness of these measures required improvements. The inspector reviewed a sample of the daily fire checks and found that the doors were checked and signed off by staff on the day of the inspection and the days leading up to it as operating however, when the inspector found a number of doors were not closing properly.

Evidence of regular evacuation drills which simulated both day and night time conditions were taking place. The documentation in place relating to evacuation drills outlined that the simulated fires took place in different locations in the centre, the length of time it took to evacuate, the evacuation route, the staffing levels and the impact the drill had on the residents. Staff training was up to date and there was personal evacuation plans in place for the residents and an emergency 'grab bag' at the door of each apartment also.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had comprehensive assessments of need completed and personal support plans which were subject to regular review. The individual social care needs of residents were being supported and encouraged and this was reflected in personal support plans and during what were called 'visioning' meetings. The residents had an annual visioning meeting where the residents' interests, likes, skills, talents, and their health and well-being were reviewed. It was evident from a review of these plans that residents were receiving care which was person-centred and tailored to meet their assessed needs with regular input from multi-disciplinary professionals. The provider also sourced and arranged a specialised assessments and therapies for the residents to meet their individual needs and preferences. For example, the provider also sourced music therapy for a resident based on their keen interest in the area. Individual resident meetings took place regularly and items discussed included visits with family, medical appointments, rent and upcoming events such as Halloween.

Judgment: Compliant

Regulation 6: Health care

The residents had health care management plans in place to ensure their health care needs were met and these were reviewed regularly. Each resident also had a health care assessment completed annually. Residents had access to a range of health and social care professionals and multi-disciplinary supports as required. This was evidenced through attendance at specialists appointments, relevant multi-disciplinary professionals and their local General Practitioner (GP) as recorded in their care plans. Staff demonstrated that they were familiar with the specific health care needs of the residents and how to address them.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider ensured that staff had up to date knowledge and skills to respond to behaviours of concern and to support residents appropriately. Where required, the residents had behavioural support plans which were subject to regular review by the multi-disciplinary team. The inspector observed the staff implementing the proactive strategies during the inspection which was in line with the residents' support plans. Staff also demonstrated awareness of triggers to incidents involving behaviours of concern.

Where restrictions were in place, they were implemented in line with best practice and efforts were made to ensure that the least restrictive method was employed. There was a restrictive practice register in place which was reviewed regularly providing a clear rationale for the use of restrictive practices used however, a number of restrictive practices were not identified such as the locked press for finances and chemicals. Management indicated that they reviewed the use of door locks with a view to reduce this measure in one apartment but there was no evidence of this review on the restrictive practice register.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to ensure that residents were safeguarded from abuse in the centre. Staff had completed training in relation to safeguarding and protection and were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse. There were no current safeguarding concerns and there was evidence that previous concerns were monitored, reviewed and dealt with appropriately. Residents had intimate care plans in place which detailed their support needs and preferences.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ohana OSV-0007781

Inspection ID: MON-0029343

Date of inspection: 07/10/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The new PIC commenced in Ohana on 8/11/2021. As part of the handover the new PIC has developed a schedule for completion of Quality Conversations in Ohana to ensure all Quality Conversations are completed in line with SPC policy. The PIC identified Quality Conversations with two employees as overdue and has scheduled same for completion as per 26/11/2021.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC has implemented a governance & management presence in Ohana since commencing in her role on 8/11/2021 as follows: - Daily contact in the morning (after PIC reviewed night report on DMS) with the staff on duty via phone calls to discuss plans for the day and identify any matters arising. - Regular PIC presence in Ohana, at least 3 times a week – more often, if required to review delegated duties, completion of audits, familiarity for people supported, ensure cleanliness of premises, oversee duties during night shifts. - Completion of Quality Conversations as per policy and schedule to discuss delegated duties and actions with employees. - PIC to further implement and develop On the Job Mentoring (OJM) for staff team in Ohana to build competences. This will be documented on SPC OJM forms. - Adherence to audit schedule and follow up on actions identified as part of Quality Conversations. - Completion of team meetings – if necessary, during COVID via Microsoft teams and ensure that all employees read and sign minutes. - Regular management meetings and Quality Conversations between PIC and PPIM to discuss matters arising in Ohana.	

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Provision for Service Documents are in place for both gentlemen in Ohana. The PIC can confirm that both Easy Read documents were explained to the people living in Ohana, which has been documented and signed by staff and the PIC.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Outstanding Quarterly Notifications for the second Quarter 2021 were submitted by the PIC immediately after the inspection took place on the 08/10/2021.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The PIC has addressed gaps in the recording of staff temperature checks. During the daily phone calls in the morning the PIC is reminding the staff team to adhere to all Infection Prevention Control and COVID related screening mechanisms in place in SPC. The PIC is further checking on completion of same during her regular visits in Ohana.

SPC has developed a comprehensive IPC audit tool, which will be rolled out as a Practice Development across the service latest by 19/11/2021 to ensure oversight by staff teams and the provider on IPC within the service.

The PIC is currently reviewing the cleaning schedules for both apartments in Ohana to ensure all areas and equipment are included and cleaning completed. The updated cleaning schedules will be implemented by 26/11/2021. PIC will oversee implementation and completion of same.

The bathroom for one gentleman has been painted since the inspection took place and the PIC has requested installation of a towel handrail, which will be installed by maintenance latest by 01/12/2021.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Identified issues regarding fire doors were rectified immediately after the inspection took place. All fire doors are now working properly and PIC was notified of same as part of the handover when commencing on Ohana on the 8/11/2021.

The PIC will discuss completion of fire checks at the next team meeting on 01/12/2021 with the staff team. PIC will ensure all employees will receive minutes and sign off on

same.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: As part of handover and commencing as manager on the 8/11/2021 the PIC has commenced a full review of restrictive practices for both gentlemen living in Ohana. This review will be completed by 08/12/2021 and documentation completed as per SPC policy.	

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	26/11/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	08/11/2021
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	17/11/2021

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.	Not Compliant	Orange	26/11/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	01/12/2021
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	08/10/2021
Regulation 07(4)	The registered	Substantially	Yellow	08/12/2021

	provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Compliant		