Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	No 4 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	06 August 2024
Centre ID:	OSV-0004573
Fieldwork ID:	MON-0043905

About the designated centre

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

This centre is located in Cork City suburbs. It is within access to shops, transport and amenities. It comprises of two self contained apartments and an adjoining house catering for three residents. A maximum of five adults can be supported to reside in this centre. It has been adapted to meet residents' needs and is a ground floor premises. This centre was set up to provide a specialist service for persons with an intellectual disability including autism. It has an integrated day service. The centre's focus is on understanding and meeting the individual needs of each resident, by creating as homely an environment as possible. Residents are encouraged to live a meaningful everyday life by participating in household, social and leisure activities. Each resident's needs are assessed and a plan put in place to meet their needs. As residents' needs change, their individual plan of care is adapted and appropriate supports provided by staff. The ethos in this centre is to build a better world for every human being. The organisation works to develop supports and services based on the needs and choices of each individual. Residents are supported by a staff team with a skill mix of nursing and social care both by day and night.

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 6 August 2024	09:00hrs to 17:00hrs	Laura Meehan	Lead

What residents told us and what inspectors observed

This was an announced inspection completed within designated centre No. 4 Seaholly. The centre was operated by registered provider and was located on a large campus near the outskirts of the city. The purpose of the inspection was to review the ongoing levels of compliance within the centre and to assist in the recommendation to renew the registration of the centre for a further three year cycle.

On arrival to the centre the inspector was greeted and welcomed by the person in charge. While completing a brief introductory meeting the inspector also observed the coming and goings in the centre. Residents were observed preparing to commence their day and to attend activities in the local community. Staff were observed supporting residents in accordance with their plans including behaviour supports plans with respect to choice of clothing. The centre was provided with vehicles to ensure these activities could be promoted.

The inspector did attempt to engage with residents in the centre. Two residents in the centre do not engage with unfamiliar staff and this was respected. Staff spoken with could clearly articulate the support needs of these residents and how important continuity of care and consistent staff were for these individuals to maintain a good quality of life. Staff spoke of activities one resident enjoys which had recently been reintroduced to the centre. They enjoyed caring for animals, and chicken were present on the campus which the resident cared for with the support of staff. They fed the chickens daily and cared for their coop. They also grew vegetables on the grounds of the campus.

Two residents living in the main area of the centre smiled and interacted in a positive manner with staff but chose not to interact with the inspector. This was respected. These residents communicated through nonverbal means such as gestures and pictures. The residents appeared very comfortable in the company of the staff. Staff spoke of residents' life in the centre and what they enjoyed to do. It was evident to the inspector through these interactions that staff were keenly aware to the support needs of residents. This included personality traits such as liking all the lights on in the centre, or having certain clothing for times of the year. They enjoyed a trip to local gardens on the day of the inspection.

Upon return from their day service one resident did come to the office briefly to meet with the inspector. They smiled and laughed with the inspector and staff present. They had returned from their day activity and staff supported them to have a cup of tea on their return. Staff spoke of the resident having a choice if they wanted to go to their day service or partake in activities in the centre during the day.

The centre was comprised of three main living areas with a capacity for 5 residents Two areas of the building had been converted to self-contained living areas to meet

the assessed needs of two individuals. These areas had been reviewed to ensure the living environment promoted a safe environments for both residents. This included suitable decorations and at times minimalistic items present. However, in these areas it was noted that while fire doors were present a number of these were locked using manual coded which were not connected to the fire system or key locked. This will be discussed under Regulation 28; Fire precautions.

The main area of the house was observed to be tastefully decorated and clean. In the hallway there was a table containing easy to read information for residents. Photographs of the residents and their staff team were visible throughout communal areas. The kitchen area provided ample storage for food. It was noted that there was adherence to restrictive practices measures within the centre. For example, it was noted at specific times during the day the kitchen area was to be closed to reduce the risk of harm to one resident. When the resident was not present the door was open with free access to the area. When the resident returned staff informed others that the door was being locked as per process.

One room in the centre had been adapted to store medications and medical equipment for the centre. The inspector observed staff returning medications and equipment following a social outing in accordance within the centre policy. The staff present could speak of the procedure and why is implemented as such. While completing a walk around of the centre it was observed by the inspector that a medicinal product used to thicken fluids was stored in a locked secure location within the centre. This was highlighted to the person in charge on the day of the inspection and will be discussed in more detail under Regulation 29; Medicines and pharmaceutical services.

Surveys completed for all five residents contained positive feedback with some highlighting the staff support provided. The next two sections of the report present 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

This was an announced inspection completed within the designated centre No. 4 Seaholly. The purpose of the inspection was to monitor ongoing compliance to the Health Act 2007 and relevant regulations to assist in the decision to renew the registration of the centre for a further three year cycle. The provider had submitted a full application to process the renewal of the registration. This was reviewed by the inspector and was found to incorporate the required information such as the floor plans of the centre, evidence of insurance and a planning declaration. There were some amendments required to the Statement of Purpose including clarity on

the organisation structure.

The registered provider had appointed clear governance structure to oversee the management of the centre. This required to include the governance responsibilities over a 24 hour period within the centre and the provider oversight of this. A suitably qualified and experienced person in charge oversaw the day to day operations of the centre. At this time of the inspection they were supported in their role by a team leader. The person in charge reported directly to the person participating in management. There was clear evidence of communication within this level of the governance team through governance meetings and one to one communications.

Overall, the provider had implemented effective measures to ensure the centre was operated in a safe and effective manner. This included the implementation of a range of monitoring systems such as six monthly unannounced visits to the centre and local auditing. Where actions were identified an improvement plan was developed and monitored by the governance team. Some improvements were required to ensure monitoring systems utilised identified all areas of non-compliance.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had ensured the application to renew the registration of the centre for a further three year cycle was submitted. This included the payment of fees and the submission of the required prescribed information. The inspector completed a review of all prescribed information to ensure the information submitted was correct and reflective of the operations of the centre. While the statement of purpose did require review this will be discussed under Regulation 3: Statement of Purpose.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a person in charge who, based on documentation reviewed in advance of this inspection, was appropriately qualified and experienced to hold the role. This individual was full-time in their role and maintained effective oversight over this designated centre with the support of team leader and staff team.

While holding the role of person in charge in one centre, they also held governance responsibilities in four other designated centres.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had appointed a suitable staffing skill mix to the centre. As part of this the residents accessed nursing care as required. At times, relief staff were used to maintain safe levels of staffing to support residents' needs. The person in charge was noted not to be on the staff roster of the centre. The staff responsible on the day shift was noted along with individuals allocated staff supports.

The person in charge maintained a planned and actual staff roster of the day staffing allocation within the centre over the day period, while the night coordinator located on the campus completed the review of staffing in place to ensure the continuity of care at night. There was not evidence the person in charge had oversight of the staffing supports in place at night. For example, the person in charge was not aware that one staff had completed 12 night duty shifts in a 14 day period on campus, of which 5 were in this centre.

The registered provider ensured continuity of care for residents through the allocation of regular staff known to the residents including relief staff. The staff spoke of the importance of this.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had ensured the centre was adequately insured. The evidence of this was submitted as part of the application to renew the registration of the centre and was reviewed by the inspector.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had ensured the allocation of a governance structure to oversee the operations in the centre. Clarification was required however, as the inspector observed differing structure both within a fire folder and the Statement of Purpose. Also the organisation structure within this document did not include the night duty co-ordinators who held responsibility over a number of governance areas including:

- Night duty roster
- Supervision of staff who completed night duty hours and
- Oversight of training of night duty staff members.

The person in charge was supported by an appointed team leader and reported directly to the person participating in management, allocated to the centre. It was not clear to whom the night coordinator reported to, as one document reflected the team leader while another stated the person in charge.

Through effective monitoring systems, oversight was maintained and actions set to ensure any issues were addressed in a timely manner. An audit schedule was in place to ensure all areas were reviewed. This included such monitoring as:

- Six monthly unannounced visits to the centre by representatives of the provider. This was last completed in May 2024
- An annual review of service provision last completed in January 2024
- Safeguarding reviews
- Restrictive practices reviews and
- Fire safety.

Following the completion of all monitoring systems an action plan was developed to ensure any actions were addressed in a timely manner. The person in charge delegated the responsibility of completion of a number of duties including fire checks and a number of audits. While this identified a number of actions to be completed within the centre, this and other monitoring systems utilised had not identified a number of areas of concern. This included for example:

- Need for review of risk assessments to reflect the correct risk rating.
- Effective fire evacuation drills
- Adherence to policy with respect to complaints.

Staff were afforded the opportunity to raise concerns through several platforms including team meetings and informal visits. Each staff also received induction to the centre and the person in charge and team leader were available as required. It was noted however, that staff completing night duties did not attend team meetings. Whilst documentation reviewed stated this could be completed through a video conferencing platform, this facility was not offered to staff to ensure all staff had the opportunity to raise concerns.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development and review of the statement of purpose for the centre. There was evidence that the document was regularly

reviewed and updated as deemed to be required. However, on the day of the inspection it was noted that some areas required to be reviewed. This included:

- Clarity on the person in charge remit within the organisation.
- The organisation structure did not incorporate the night duty supervisors.
- The document stated 2 core relief however there were approximately 6 noted to be on roster especially night duty roster. This required clarification.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had ensured the development of a complaints procedure to ensure all residents and their representatives were supported to submit a complaint as they saw fit. This included the appointment of a complaints officer, a complaints pathway and a timed approach to complaints. There had been an accessible document developed to support resident through the complaints process. It was evident through review the complaints log that staff members support resident to utilise the complaint process and to submit a complaint on their behalf.

The inspector reviewed the complaints folder maintained by the person in charge within the centre. Within the documentation reviewed there was not evidence of adherence to the provider's policy, including communication with the complainant and, where possible, the satisfaction of the complainant. The provider had appointed a third party to investigate a complaint should a resolution not be obtained within the allocated timeframe, however this had not been implemented. For one complaint reviewed by the inspector, there was no evidence of review by the complaints officer despite the complaint being open more than six months.

Judgment: Not compliant

Quality and safety

As stated previously this was an announced inspection completed within the designated centre No. 4 Seaholly. Through review of documentation, speaking with the staff team and observations throughout the day, this inspection reviewed the quality and safety of the centre. It was identified that some improvements were required in such areas as risk and fire safety. While the person in charge had ensured the resident had a comprehensive personal outcomes measures in place, documentation did not accurately reflect the participation and progression of these. This required review.

The inspector completed a review of risk as part of the inspection. However, upon

review of the processes in the centre, it was identified that these required review to ensure the risk rating allocated to the identified risk reflected the current likelihood and impact. Further improvements were required to ensure adherence to the organisational policy. In addition to risk, improvement were required with respect to the safe evacuation from the designated centre. This included safe opening of fire doors in the event of an evacuation in all areas of the centre.

The residents was supported to participate in actives in the local and wider community. The staff spoke of family connections with residents the centre and how they maintained links in the local and wider community. While the staff spoke of the favourite activities personal outcomes measures with the inspector what the documentation and evidence of progression to allow for effective review of goals within the centre.

The residents currently living in the centre was supported to be aware of their rights where possible They had access to advocacy services should they require them. The residents through regular resident meetings and staff interactions, was consulted in the day to day operations of the centre and any changes which were to be implemented.

Regulation 20: Information for residents

The provider had ensured the development of a residents guide. Upon review of the document it was evident this included the information required as set out in regulation 20 including the terms and conditions of residency.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured 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. A quarterly oversight tool was completed to aid quality and management. This was last completed July 2024 by the person in charge.

The risk register outlined the controls in place to mitigate the risk. Such risks addressed within the risk register included:

- COVID 19
- Storage of chemicals
- Lone working
- Manual handling

While the risk assessments in place had been reviewed, this review did not include a review of the risk rating of the identified risk. The impact and likelihood of the risk had not been reviewed in a number of years for some identified risks. For example for one risk assessment completed in July 2022 pertaining to a resident leaving the centre to gain access to fluids this was risk rated high. Despite effective control measures in place and a reduction in engagement in the risk, the rating remained that of July 2022.

Also, it was noted while some risk assessment reviews noted to continue current plans, these had not taken into account additional control measures implemented since previous review such as medication reviews or periodic service reviews.

Judgment: Not compliant

Regulation 28: Fire precautions

Overall, over the course of the inspection it was found the registered provider had ensured there were effective systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. A fire warden was appointed daily. Staff completed daily and weekly checks of firefighting equipment and measures including:

- Fire exits
- Fire panels,
- Fire emergency lighting and
- Fire extinguishers.

As part of the walk around however, it was noted that a number of fire doors were either locked with a manual opened code or with a key. These were not linked to the fire system and no break glass key available for those key locked doors. This required review to ensure safe evacuation could be completed.

Staff spoke that fire and evacuation drills were completed to promote resident awareness of what to do in an emergency. It was noted that each resident in the centre had a personal emergency evacuation plan which included what assistance may be required. Fire evacuation drills had been completed with differing scenarios to reflect plans in place and to ensure its effectiveness.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Since the previous inspection there was evidence of improvements in the areas of

medicines and medicinal products. An area of the centre had been dedicated for the storage of all products in a safe and effective manner. However, the inspector did observe that a medical product use to thicken fluids was not stored in a safe manner and left on the counter top in kitchen area. It was noted to be stored in an open press in another area of the centre. This required review.

The provider had ensured there were effective measures in place for the safe administration of medications. Only staff who had completed the required training completed this duty. Regular checks on as required medications were completed to ensure sufficient stock was present and in date. A system was in place for the return of out of date medications to the local pharmacy.

Should a resident require to bring medications on a social outing a procedure was in place to ensure this was completed in a safe manner. The inspector observed a safe member returning this medication in accordance with the procedure on return from the social outing.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector completed a review of the four individualised personal plans of the residents currently residing in the centre. This was regularly reviewed by the person in charge and staff team including the appointed key worker. The plans was found to be holistic in nature and reflected the needs and interests of the residents. The residents' personal outcome measures guided the staff team in supporting residents with identified needs such as community activation, areas of interests and family relationships. Improvements were required to ensure there was clear evidence of participation and progression of these personal outcomes. Upon review the inspector noted gaps within this documentation.

Areas of support were addressed including:

- Communication and interaction
- Self-help and daily routines and
- Leisure and social skills.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

As required the residents within the centre were supported in the area of challenging behaviour. The support measures in place were reviewed through six monthly periodic service reviews which reviewed current plans in place and

addressed any changes since previous review including medication reviews, reduction in behavioural incidences etc. Staff were observed supporting the resident in accordance with the review plans in place. Supports were spoken of being in place to reduce the likelihood and impact of a behavioural incident.

It was noted however, that while these reviews were completed the behaviour supports plans were not. It was observed that one plan had not been reviewed since October 2014 but had been deemed to remain relevant to the resident. All updates were noted to be present in periodic service reviews did not consistently reflect what was present in plans. Staff stated they worked from guidelines in reviews.

As required supports to support residents in this area were accessed to ensure a holistic and multi-disciplinary approach to support. This included psychology and psychiatry supports. The behaviour supports in place were implemented in conjunction with the resident's mental health support plan. This plan also guided staff on the use of medications as required and access to psychiatry support.

Judgment: Compliant

Regulation 9: Residents' rights

The person in charge had ensured that the centre was operated in a manner which respected the rights of all individuals currently residing in the centre. The residents were consulted in the day-to-day operations of the centre through key worker and resident house meetings. Staff were observed offering the resident choice on the day of the inspection with respect to clothing mealtimes and activation.

The person in charge ensured the resident was provided with up to date information pertaining to the centre through the use of accessible information where possible.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No 4 Seaholly OSV-0004573

Inspection ID: MON-0043905

Date of inspection: 06/08/2024

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: The person in charge will; • Ensure that their routine allocated hours are identified on the planned roster. Some hours will not be rostered where flexibility is required to perform full PIC duties [10/08/2024] • Ensure that the roster for the centre is reviewed at least fortnightly. [20/08/2024] • All leave cover in the centre, coordinated by the social care leader and night supervisors and reviewed by the person in charge. [02/10/2024]	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure that • the night-time governance and management systems are reviewed including the 'Night Time Governance Protocol' to reflect the management structure in the centre. [16/08/2024] • The Risk management system is reviewed i.e. all the risk assessments reflect the current risk in the centre and is reflective of the current control measures in place. [08/10/2024] • An on-line system is available for team members to attend staff meeting where they are unable to do so in person. [08/10/2024] • Fire drills are conducted to include scenarios within the centre [13/10/2024]	

• Review local complaints log to ensure it records the steps taken to resolution and details the outcome, ensuring the complainant is aware of the steps the complainant can take if not satisfied with the outcome. [15/10/2024]

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The registered provider will review the statement of purpose for the centre to clarify
• the overall remit of the Person in Charge
• The role of the night supervisors in the designated
• The staffing levels allocation of relief cover for annual leave [31/10/2024]

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The registered provider will ensure for that the provider process for the management of complaints is followed by ensuring
- The complaint is logged in the Complaints log and examined to identify what steps were taken prior to the issue reaching complaint stage
- The complaint is reviewed to establish if it can be resolved locally
- The complaints log is reviewed by the Team Leader and PIC on a regular bais to ensure progress on finding resolution is logged
- All consultation with the complainant are logged and time lines within the policy are followed. [15/10/2024]

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Provider will ensure that the PIC and Team Leader consult with the Team to update the risk register for the Centre.

This review will include a review of the current risks in the Centre and the control measures in place to manage these risks. The residential risks will then be scored and the register updated. [08/10/2024]

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider has ensured that

• an environmental risk assessment has been carried out in the centre by the health and safety officer, with responsibility for building regulation and fire safety compliance. [12/08/2024]

• On review of the risks in the Centre it was confirmed that the safety risk to residents of having break-glass key systems or some doors linked to fire alarm system far outweighed the fire safety risks and staff continue to hold keys on their person at all times to manage this risk.

• The fire-risk assessment is updated by the health and safety officer with responsibility for building regulation and fire safety compliance. The assessment identifies the additional controls assessed to manage the potential fire risk including access to keys and scenario-based evacuation drills [15/10/2024]

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The person in charge has ensured;
• The safe storage of all prescribed medication, including thickner, in the centre. All medication is now stored in line with the medication management policy on the [07/08/2024].
• A Memo identifying the risk and patient warning information sent to designated centre on the [08/08/2024]

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:
The person in charge has;
• Reviewed person centred plans in the centre [14/08/2024]
• Provided training for team leader with the person centred planning facilitator in relation to evidencing participation of residents in their plans and progression of teir individual personal outcomes. [14/08/2024]
• Updated the information gathering and meaningful day activities linked with individuals goals for residents [07/10/2024]

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	02/10/2024
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	15/10/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Not Compliant	Orange	15/10/2024

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	15/10/2024
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	08/10/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	15/10/2024
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre	Substantially Compliant	Yellow	08/08/2024

	has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/10/2024
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	15/10/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	07/10/2024