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. 5 Portsmouth
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	03 December 2024
Centre ID:	OSV-0008761
Fieldwork ID:	MON-0043930

About the designated centre

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

No. 5 Portsmouth comprises two houses located on a campus operated by the provider on the outskirts of Cork City. It can provide full-time residential services to a maximum of six adults of both genders over the age of 18. The centre can support those with intellectual disabilities including those with autism. The first house is a detached bungalow which is divided into a larger area for three residents and a self-contained apartment for one resident. Rooms in this house include four individual resident bedrooms, staff rooms, a kitchen, a living-dining room, and a kitchen-dining room. The second house is a two-storey detached building with a capacity for two residents. There are two rooms in this house that could be used as resident bedrooms while there is also a living room and a kitchen-dining room. Staff support is provided by the person in charge, a social care leader, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 3 December 2024	09:30hrs to 17:55hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

All three residents living in this centre were met by the inspector along with staff members supporting them. Some respectful and caring interactions were observed and overheard between staff and residents. Such residents appeared to be comfortable in the presence of staff.

This designated centre was comprised of two separate houses, both located on a campus setting. One of the houses had a capacity for two residents where one resident was living at the time of inspection. The other house was subdivided into a larger area with capacity for three residents and an apartment area for one resident. One resident was living this apartment area while another resident was living in the larger area. Both houses were visited during this inspection with all three residents met by the inspector. None of these residents engaged significantly with the inspector.

However, one resident did say hello to the inspector and shook his hand. The inspector sat with this resident for a brief period in their home's living room. During this time the resident said some other words such as the name of a staff member who would be supporting them later in the day. The staff member who was supporting at this time was observed to offer the resident a choice of drink by bringing them a box of tea bags and a hot chocolate container. The resident pointed to the latter with the staff member then making and bringing a cup of hot chocolate to the resident.

Another resident was met in their home in the dining-living area. This resident did not interact when first met by the inspector but seemed content. The same resident had been met during a previous inspection in May 2024. At that time the resident had been living on their own in one house and it was highlighted then that the resident was benefitting from a quiet low-arousal environment that had resulted from this. However, in the following month a second resident had moved into the same building and notifications received shortly after suggested that the resident was being adversely impacted by noise coming from this second resident. This included having their sleep disturbed. Since then some changes had been made which included a transition of residents between both houses of the centre.

Staff spoken with during this inspection indicated that the resident was no longer being impacted by noise from any other resident. Given the changes made, the resident was living on their own in one living area and the inspector was informed during this inspection that there were no plans to move anyone in with the resident at the time of this inspection. Communication received from the provider relating to this resident before the current inspection indicated that this resident was being considered for de-congregation (a move away from the campus setting into the community). When this was queried during this inspection, it was indicated that the resident was on a list for de-congregation but was not on a priority list for this.

As the inspector spent more time in this resident's home, at one point, while the staff member supporting them was on a telephone call, the resident approached the inspector and handed him an item of clothing. It appeared that the resident wanted the inspector to help the resident put this on. The inspector suggested that they sit on a couch in the dining-living area and wait until the staff member had finished their call. When this happened the resident handed the item of clothing to the staff member who promptly assisted the resident. The same staff member also assisted the resident with a meal while the inspector was present.

Throughout the inspector's time in this resident's home, it was observed and overheard that this staff member was very caring, respectful, upbeat and warm in their interactions with the resident. For example, when preparing the resident's meal the staff member had to use a blender but warned the resident before using this about the noise. The same staff member later supported the resident to go for a walk and to get a soft-drink. The house where this resident lived did not have its own dedicated transport vehicle so had to make arrangements to borrow from other areas on the campus. The inspector was informed though that the house was due to get its own dedicated transport the week following this inspection. The other house already had its own transport.

One resident used this latter transport and this resident was met by the inspector in their home after they returned from the day services. The resident was eating some crisps in their home's kitchen-dining area with staff members present at the time. The resident did greet the inspector and gave one word responses as the inspector chatted to the resident. It was observed that the resident seemed comfortable with the staff present who later went on a walk with the resident. Before they left, such staff indicated that the resident had been at a particular day services earlier in the day where they had also gone for a walk. Aside from meeting the three residents, the inspector also reviewed the suitability of the houses where they lived.

In general, these were seen to be clean, well-maintained and well-presented during this inspection. It was also highlighted that the location of one house better suited the mobility needs of one resident who had transitioned into their current home in recent months. Efforts had been made to make residents' home homely, such as having framed photos on display. It was was seen though that the fire panel alarm for the entire campus was located in a staff office in one house. This meant that if the fire alarm was activated in another designated centre on the campus, the alarm would sound in this house. It was indicated to the inspector that the alarm sounding in such a scenario was capable of waking one of the residents living in that house. Some environmental restrictions were also observed, some of which were related to the needs of residents. However, as will be discussed later in this report, not all of these restrictions had been recognised or documented as such.

Furthermore, in the house that had a capacity for two residents, one room that could be used as a resident bedroom was being used as a staff office at the time of this inspection. Another room in the same house was designated as an office on the floor plans that the centre was registered against. However, this room was locked on the day of this inspection. When this house had been inspected previously in June 2024, this room was being used as an office by a member of management who

was not currently involved with No.5 Portsmouth. During the feedback meeting for this inspection, the inspector was assured that this individual was no longer using this office.

In summary, the houses visited during this inspection were seen to be appropriately presented. The three residents met during this inspection did not engage significantly with the inspector. However, these residents appeared comfortable with the staff supporting them. Such staff also interacted with residents in an appropriate and respectful manner.

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 first inspection of this centre in its current format since registration. It was indicated that residents' current homes were better suited to their needs. Some actions were identified relating to restrictive practices.

When this centre was first registered in June 2024, it consisted of one house only for a maximum capacity of four residents. That house had previously been part of another designated centre operated by the provider and had been visited during a May 2024 inspection of that centre to inform the initial registration of No.5 Portsmouth. The registration of No.5 Portsmouth had been expedited by the Chief Inspector of Social Services following a request from the provider in response to the particular needs of one current resident. This resident had high needs and moved into this centre in June 2024. However, due to a change in circumstances and to ensure that the needs of this resident were not adversely impacting another resident in the centre, in September 2024 the provider applied to vary the centre's conditions of registration. This was done in order to add a second house to the centre and increase the overall capacity to six.

This second house had previously been part of other designated centres operated by the provider on the same campus and had been visited during a previous inspection of one of these centre in June 2024. The provider's application to vary the registration conditions of No.5 Portsmouth was subsequently granted and resulted in the transition of two residents between both houses of the centre. As No.5 Portsmouth had not been inspected previously in its current format, the decision was made to conduct the current inspection to assess the supports to residents. On this inspection, the inspector was informed that these transitions had gone well and that residents had been supported with these transition in order to ensure that their needs were met. This was positive although the needs of one resident remained high while there were some suggestion that the needs of one were changing so this would need to be kept under review. Aside from this, during this inspection

regulatory actions were identified in some areas, particularly relating aspects of restrictive practice recording and notifying.

Registration Regulation 8 (1)

Since the initial registration of the centre, the provider had submitted an application to vary the centre's conditions of registration to reflect an increase in the footprint and capacity of the centre. This application was accompanied by the required documents and fee in keeping with the requirements of this regulation.

Judgment: Compliant

Regulation 15: Staffing

Discussions with staff and management along with staff rotas reviewed from recent months indicated that appropriate staffing levels were being maintained in the centre to support residents. Maintaining such levels was important given the particular needs of some of the residents living in this centre. To ensure that these levels were being appropriately maintained for one resident, the provider had for a period availed of high numbers of agency staff (staff sourced from an external agency). The use of such agency staff had decreased in recent times and the inspector was informed that agency staff being used at the time of inspection, worked regularly with the resident. For another resident, when the house that they lived in had been previously inspected in May 2024, it was identified that the resident did have regular staff working with them by day but not by night. On the current inspection, this situation had improved somewhat although it remained the case that the resident's staffing by night was more irregular compared to the day time.

Under this regulation, the person in charge is required to ensure that they have obtained specific documentation relating to all staff working in the centre including agency staff. Given the use of agency staff, the inspector requested and was provided with staff files relating to five different agency staff. For the most part, the agency staff files reviewed were found to contain all of the required documentation such as written references, full employment histories and evidence of Garda Síochána (police) vetting. On the day of inspection documentary evidence of Garda vetting for one agency staff was not provided but this was submitted to the inspector the day after the inspection. However, for a second agency staff member, no written references were in place while two forms of photo identification for them had expired.

Judgment: Substantially compliant

Regulation 21: Records

Under this regulation records must be kept of any occasion when a restrictive practice is used in respect of a resident and how long it is used for. Within the centre there had been times when a locked half-door on kitchens in two residents' living areas had been used. While a log of when this was used was being kept for one resident, it was not being kept for the other resident.

Judgment: Substantially compliant

Regulation 23: Governance and management

A social care leader had been appointed since the centre was first registered to support the running of the centre. Arrangements were also in place to provide for out-of-hours support for staff if required. Staff members spoken with were aware of this while information about out-of-hours support was seen to be in display. In addition, since this centre had been registered in June 2024, a representative of the provider had conducted an unannounced visit to the centre on behalf of the provider.

This visit was conducted over two days in October and November 2024 with the current houses of the centre visited. This unannounced visit was reflected in a written report that was made available to the inspector for review. From this report, it was seen that the unannounced visits focused on areas relevant to the quality and safety of care and support provided to residents while an action plan was put in place in response to any areas for improvement identified. This action plan outlined time frames and assigned responsibilities for addressing areas of improvement. The action plan for the unannounced visit had been updated to reflect progress with these areas, with most actions indicated as being completed.

Conducting such provider unannounced visits is required under this regulation. The provider is also required to carry out an annual review for the centre. An annual review had yet to be completed for this centre but given the length of time since the centre was first registered, this was not required to be completed at the time that this inspection. Aside from such regulatory requirements, self-assessments and reviews were also being conducted in areas such as restrictive practices, fire safety and infection prevention and control. Despite these, this inspection did find regulatory actions in most regulations reviewed during this inspection including for restrictive practices, fire safety and infection prevention and control. This indicated that aspects of the monitoring of this centre did need some improvement to ensure all relevant matters were promptly identified and addressed.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Under this regulation, any restrictive practice in use in a centre must be notified to the Chief Inspector on a quarterly basis. Since some residents had transitioned between the two houses of this centre, notifications of restrictive practices in use for both houses had been submitted. However, based on observations the inspector was not assured that all environmental restrictive practices had been notified. For example, the use of Perspex screens had not been notified even though these were is use in both houses and listed on the centre's restrictions logs. In addition, a locked store room had been notified for one house only but locked stored rooms were seen in both houses. The inspector was informed that these had been locked since residents had transitioned.

Judgment: Not compliant

Quality and safety

Both houses visited during this inspection were seen to be clean and provided with appropriate fire safety systems. Relevant documents was also reviewed during this inspection including residents' personal plans.

The houses where residents lived in were observed to be appropriately presented and clean on the day of inspection. Both of the houses were equipped with appropriate fire safety systems, such as emergency lighting and fire extinguishers, which were being serviced at regular interval by external contractors to ensure that they were in proper working order. The two houses were also seen to have environmental restrictions in use. Most of these were recorded in restrictive practices logs but not all were including some locked store rooms. Both houses though were observed to have sufficient space for residents to receive visitors in as each of the three residents currently had their own individualised living areas. Aside from this the inspector also reviewed the personal plans of two residents during this inspection but the inspector was informed that such residents did not have accessible version of these plans in place.

Regulation 11: Visits

Taking into account the number of residents that were living in the centre at the time of this inspection, there was sufficient space for residents to receive visitors in

private given the layout of both houses. This could be impacted though were any additional residents to move into the living area that had a capacity for three residents. Discussions with staff and documentation read by the inspector indicated that residents had received visitors to the centre. For example, the inspector read a compliment that had been made by relatives of a resident with the relatives having praised staff for supporting the visit. This had allowed the relatives to stay for an extended visit.

Judgment: Compliant

Regulation 17: Premises

Both houses which made up this centre were seen to be clean, well-maintained and well-presented when visited during this inspection. Each resident had their own individual bedrooms which were appropriately furnished with efforts made to make residents' homely. For example, in one house it was seen that the living-dining room had a framed photograph of a resident with some relatives. Appropriate bathroom facilities were also provided in both houses while sufficient space was also available for storage.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk registers were in place for both houses of the centre. These outlined identified risk affecting residents living in each house with each risk having a corresponding risk assessment that outlined control measures for mitigating the risk. When reviewing these risk registers, it was noted that both were marked as having been recently reviewed. A system for recording incidents was also in operation which is important as part of a risk management system. It was highlighted that there was variance in the level of detail contained in some incident reports compared to others. This had been identified by management of the centre and the inspector was informed that measures had been taken to address this.

Judgment: Compliant

Regulation 27: Protection against infection

Expired products had been seen in both houses previously when they were previously inspected in May 2024 and June 2024 respectively. Despite this, during

the inspection, the inspector observed a box of face masks in one house that had expired in June 2024. In the other house another box of face masks was present there that had expired in August 2023. Training records reviewed indicated that one staff member had not completed training in infection prevention and control although the majority of staff had.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety systems provided in both houses of the centre included fire alarms, emergency lighting, fire extinguishers, fire blankets and fire doors. Such systems were subject to regular maintenance checks by external contractors while internal staff checks were being conducted on a weekly basis based on documents reviewed in both houses. Fire drills had been completed following the transition of residents between the houses of the centre with records of these reviewed indicating low evacuation times. Residents had personal emergency evacuation plans (PEEPs) provided outlining the supports they needed to evacuate if required while day and night evacuations protocols were in place for both houses. The protocols and PEEPs read by the inspector had been reviewed in recent months. Staff had completed training in fire safety, but training records provided indicated that four staff had yet to complete specific training in fire evacuation.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plans of two residents were reviewed during this inspection. In general, these were found to have been recently reviewed and contained guidance on supporting residents' needs in various areas. However, the following were noted when reviewing these plans and from discussion with management;

- One resident's last multidisciplinary annual review had taken place in July 2023 while the other resident's had taken place in May 2023. No such annual review had taken place since then although the inspector was informed that that the transition of residents between houses had delayed these and that they were scheduled to take place in the month of this inspection.
- The epilepsy care plan reviewed for one resident on the day of inspection was not completed in full. On the inspection day, the inspector was informed that this was due to be reviewed the following day with a copy of this subsequently provided.
- Documentation reviewed in another resident's personal plan made reference to inconsistent staff approaches regarding a particular aspect of their care.

When this was queried, the inspector was informed that this had been raised with such staff and that this had improved.

- When reviewing same resident's personal plan, it was seen that the resident's mental health stay well plan was overdue a review since October 2024. The inspector was informed that two other plans were being followed while this awaited review. One of these had been updated in November 2024 and the other had been last reviewed in June 2024. It was noted though that the latter plan referenced the resident as living somewhere else rather than their current home. It was acknowledged though that this resident had been subject to regular review generally in recent months given their needs.
- No accessible versions of residents' personal plans were seen by the inspector who was later informed that these were not in place despite this being a requirement of the regulations.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Given the needs of some residents living in this centre, guidance was available within residents' personal plans on supporting residents to engage in positive behaviour. Staff spoken with demonstrated a good awareness of such guidance. This provided assurances that such staff had been equipped with the necessary knowledge to support residents in this area. However, a behaviour support services report for one resident from December 2023 recommended that the resident was to have a visual schedule. This was not seen in the resident's current home and when queried, it was confirmed that it was not in place.

Relevant training in de-escalation and intervention had been provided to staff. However, when reviewing training records provided three staffed were marked as "watched online video". When the inspector queried what this meant, he was informed that staff had yet to complete practical training in this area and were waiting on training dates to be arranged for this. The same training records also indicated that three staff were overdue refresher training in the same area.

The provider did have processes in place for restrictive practices to be reviewed while logs were being maintained in both houses of restrictive practices. However, from observations during the inspection, the inspector was not assured that all restrictive practices had been recognised as such. For example, the restrictive practices logs indicated that there was only one locked store room in the centre but the inspector observed three locked store rooms between both houses. In addition, a resident living in one house could use the stairs but the house where they lived had a lockable stair gate in place that was seen to be in use on the day of inspection. This was not recorded in the restrictive practices documents seen by the inspector.

Judgment: Substantially compliant

Regulation 8: Protection

Prior to the registration of this centre as a standalone centre, the house that had initially made up had been visited as part of a previous inspection in May 2024. At that time only one resident was living in that house and it was highlighted that such arrangements had benefitted the resident. However, by the time this centre was registered in June 2024 a second resident had moved into the house. Although the house had been subdivided at that time, safeguarding notifications indicated that the new resident was adversely impacting the first resident. It was acknowledged that the second resident had particular needs and the provider had made efforts to address the negative impacts on the first resident. This included adding the second house to this centre and the transition of residents between the houses. This contributed to no safeguarding concerns between residents being identified on the day of this inspection. However, during the feedback meeting for the inspection, the inspector was informed that a potential safeguarding matter of a different nature had been raised and was in the process of being investigated. Following the inspection, management of the centre were requested to provide the outcome of this investigation to the Chief Inspector.

As this inspection was announced at short notice, the inspector requested in advance that preliminary screening records for any safeguarding matter that had occurred or been alleged since the centre registered be provided. On the day of this inspection, records of these were not provided for two such incidents from July 2024. These two incidents had been very similar to previous incidents which had occurred in June 2024. This was raised with management of the centre during the inspection and again at the inspection's feedback meeting. The day following the inspection it was confirmed that a safeguarding referral was not sent to the provider's designated officer for the July 2024 incidents. While it was acknowledged that there was already a pre-existing safeguarding plan in place from June 2024 and further measures were taken, this indicated that the July 2024 incidents had not been subject to a preliminary screening in accordance with relevant national safeguarding policies.

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	
Registration Regulation 8 (1)	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	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	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for No. 5 Portsmouth OSV-0008761

Inspection ID: MON-0043930

Date of inspection: 03/12/2024

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 registered provider will ensure that residents receive continuity of care and support in this Centre. • Recruitment has been ongoing and remains a priority for the Centre to ensure consistency of staffing on day and night time rosters. Permanent staff have commenced and a newly appointed Social Care Leader ensures that there is a planned and actual staff roster in place. • The Person in Charge received all documentation in relation to agency staff on 04/12/24	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The registered provider has ensured that each Centre holds records in relation to the use of restrictive practices. • The Person in charge conducts an audit on the restrictions in use on a 6 monthly basis. • The Person in Charge also holds a log of restrictive practices in use. • The Person in Charge ensures any restrictions in use are sanctioned for use and reviewed as per the Provider policy on restrictive practices 'Fuller Lives, Safer Lives Policy'. • The person in charge will hold a staff meeting on 08.01.25 to ensure that all staff are reporting and recording the use of restrictions in this Centre.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The registered provider has ensured there is a clearly defined management structure in the designated Centre that identifies specific roles and details responsibilities.
• The person in Charge has an annual audit schedule in place to support them to effectively monitor the Centre.
• The Person in charge will review the comprehensiveness of internal audits in relation to restrictive practices, fire safety and infection prevention and control by 21.12.24

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Person in Charge will ensure that all environmental restrictive practices in use in the Centre are detailed on the log of restrictions to be notified to the Chief Inspector in writing on a quarterly basis.
• the Provider will ensure that the use of Perspex for safety reasons will now be recorded as a mitigating safety measure on the Centre's Risk Register rather than on the Restrictions Log as residents have full access to all functions of the television and can access it in a normative manner via remote control i.e. this is not considered a restrictive practice. 8.01.2025
• The person in charge will hold a staff meeting on 08.01.25 to ensure that all staff are reporting and recording the use of restrictions in this Centre.
The Person in Charge will review their restrictive practice self-assessment tool on 21.12.24

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The registered provider has ensured that training in protection against infection is available to all staff members. 1 staff member due this training will have completed it by

08.01.25
• All Personal protective equipment that was found to have expired was removed from the Centre on 04.12.24.
• The Centre will no longer store items of Personal protective equipment unless it is required for outbreak management or support with personal hygiene. Personal protective equipment will be purchased from the pharmacy as required.

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 effective fire safety management systems are in place and such systems are subject to regular maintenance checks.
• The person in charge monitors the weekly fire checks and ensured that each person had an evacuation plan in place.
• The fire warden will deliver specific training to staff requiring fire evacuation on 06.01.25

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 will Chair the annual multi-disciplinary reviews of the personal plans scheduled for 16/12/24. The Person in charge will ensure any actions arising from these meetings are completed.
• An epilepsy care plan for 1 personal was scheduled review on 04/12/24 as signed off by the general practitioner on that date.
• Accessible versions of the personal plans will be completed by 21.12.24

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• Therapeutic interventions are implemented with the informed consent of each resident in this Centre. They are reviewed as part of the personal planning process.
• Staff members requiring practical training in de-escalation techniques will have received this on 20.01.25
• A mental health stay well plan is currently on hold as staff have been advised by Psychology to use a recovery plan that was reviewed in November 2024.
• The mental health stay well plan will be reviewed with Psychology 31.01.25.
All restrictions in the Centre will be included in the Log in the Centre and will be notified as required on a quarterly basis to the Chief inspector 31.01.25

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The person in charge has ensured that all allegations of abuse have been notified to the chief inspector and has put plans in place to protect the residents in this Centre.
• The person in charge has ensured that the residents in this Centre have been supported to develop knowledge, self-awareness, understanding and skills needed for self-care and protection. Easy read documentation has been provided to the residents and Keyworkers support with understanding of same.
• The Area Manager omitted to send notification of incident to the designated officer for incidents that occurred in July 2024, these notifications were advised to the chief inspector and a safeguarding plan was in place. These notifications were sent to the designated officer on 04.12.24.

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(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	04/12/2024
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	08/01/2025
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'	Substantially Compliant	Yellow	21/12/2024

	needs, consistent and effectively monitored.			
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	08/01/2025
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	06/01/2025
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at	Not Compliant	Orange	08/01/2025

	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.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	21/12/2024
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	21/12/2024
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-	Substantially Compliant	Yellow	20/01/2025

	escalation and intervention techniques.			
Regulation 07(4)	The registered 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.	Substantially Compliant	Yellow	31/01/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	04/12/2024
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	04/12/2024