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:	Prosper Fingal Residential Respite Service 1
Name of provider:	Prosper Fingal Company Limited by Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	03 September 2024
Centre ID:	OSV-0001860
Fieldwork ID:	MON-0036406

About the designated centre

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

Prosper Fingal Residential Respite 1 provides respite services to approximately 90 residents and ordinarily can accommodate up to six residents at any one time. At present the centre is operating at a reduced capacity to allow for social distancing to be maintained. The designated centre is a nurse led service who are supported by care assistants which provides service to adults with varying levels of intellectual disability. Some of these service users may also have a secondary disability, such as a physical or sensory disability, autism and or mental health needs. The service also supports individuals who may have an acute illness due to mental health difficulties.The house is located in a suburban town in Co. Dublin close to a range of local amenities. The designated centre is a spacious detached two storey house, with front and back garden and parking space to the side of the building. There is an accessible bathroom and bedroom on the ground floor for service users with reduced mobility. Public transport as well as a centre bus are available. The aim of the service is to provide residential respite which is short term, in a safe and comfortable home, in response to individuals' and carers' needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 September 2024	10:00hrs to 18:30hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, on the day of the inspection, the inspection findings were positive. It demonstrated that residents were receiving a service that met their needs. However, some improvements were required with regard to individual assessment and personal plans, positive behaviour supports, staffing in relation to staff files, training and staff development, and governance and management. These areas did not appear to be negatively impacting directly on the residents' respite breaks and they will be discussed in more detail later in the report.

The inspector had the opportunity to meet the six residents that were attending the respite service on the day of this inspection. Three residents agreed to chat with the inspector. All three said they liked coming to the respite centre and said that the staff were nice. They said they had a choice in what activities they did and what food they ate. They communicated to the inspector that they felt that staff listened to them.

Activities residents participated in depended on their interests. They included going out for meals, going shopping and attending farms. On the day of this inspection, the residents had drinks and snacks on arrival from their day programme. Staff were observed to greet them warmly and engage in friendly conversation. Three residents informed the inspector that they planned to relax in the centre for the evening and that they planned to watch 'the soaps' on the television. Other residents chose to spend time in their room relaxing or using a computer.

One staff was observed to review a resident's schedule with them as to how many nights they were staying in respite and when they would see their family again. This interaction was taken at the resident's pace and not rushed. The staff member was observed using sign language in addition to verbal communication with this resident to help support their understanding.

The provider had arranged for staff to have training in human rights. A staff member communicated that staff in the centre focus on up-holding people's rights. For example, promoting choices in activities and meals on offer through the use of pictures. The inspector observed a staff member reviewing pictures at the kitchen table with a resident. They were also observed to double check with another resident that they were still happy with the food choice that was agreed for the night and the resident said they were happy with the agreed dinner.

The inspector observed the respite house to be tidy. Each resident that attended the respite centre was allocated their own bedroom and there was adequate storage facilities for personal belongings. The inspector observed pictures displayed in different areas of some of the respite users that attended the centre. There were different art supplies, jigsaws, board games, computer games and DVDs available for residents to use when on their respite break.

There was a front garden mainly used for parking. At the back of the house there was a car park as well as a back garden. The back garden had a large garden board game, a basketball net and a garden table and chairs available for use. The inspector observed some plants and flowers growing in different areas which helped make the space an inviting one.

The provider had sought residents' and family representatives' views on the service provided. This was done by way of phone calls with family members and observations or interviews with some residents that were attending on a respite break and feedback received was positive.

As part of this inspection process residents' views were sought through questionnaires provided by the Health Information and Quality Authority (HIQA). Feedback from the questionnaires was completed by four family representatives and one was from a resident who had been supported by a family representative to complete it. The majority of questions from all five questionnaires were ticked yes to represent that they were happy with all aspects of the care and supports provided in the centre. One family commented that they weren't sure about the arrangements to have visits and calls in private due to the short nature of the respite breaks. One resident ticked that choosing what they do every day could be better. The inspector did not get the opportunity to speak directly with family representatives as part of this inspection process.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection was announced and was undertaken following the provider's application to renew the registration of the centre. This centre was last inspected in May 2023. From a review the actions from the previous inspection, the inspector found that they had been completed by the time of this inspection.

For the most part, there were effective management arrangements in place that ensured the safety and quality of the service was consistent, monitored and appropriate to residents' needs. For example, there was a defined management structure in place, a full-time person in charge was employed and the provider completed six monthly unannounced visits to the centre to assess compliance levels. However, the inspector observed that, there were some gaps in the length of time between some audits being completed and some actions that arose were not dealt with in a timely manner. Periodic audits and timely response to actions identified were required to ensure that the provider had appropriate oversight of the centre and that any actions that arose were dealt with to prevent escalation.

The inspector reviewed a sample of rosters and they demonstrated that there were

sufficient staff on duty to meet the needs of the residents. However, some gaps were found in the Schedule 2 information of staff personnel files as required by the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations)

There were systems in place to monitor and facilitate staff training and development. For example, staff were receiving formal supervision and had access to training, such as how to support people in the area of eating drinking and swallowing. However, refresher training was required for staff in positive behaviour supports to ensure staff had up-to-date knowledge. Furthermore, supervision was not always occurring in line with the training provided to the supervisors.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced to fulfil the requirements of the role. They held a qualification in social care practice and they were employed in a full-time capacity within the organisation. The split their time between this and one other centre they managed. They were supported in the role within this centre by a clinical nurse manager 1 (CNM1) who was the lead staff for the centre. They demonstrated that they were familiar with the residents' care and support needs. For example, they were able to inform the inspector of any resident who had additional support needs.

Two staff spoken with communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns and they felt they would be listened to. One told the inspector that the person in charge was very approachable.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff available, with the required skills and experience to meet the assessed needs of residents.

However, the inspector observed that while the majority of information was in place in the Schedule 2 information of staff personnel files some information was not in place or found to be conflicting. Information related to:

- one staff reference provided a different employment finish date than the staff member had provided on their employment history, the inspector observed approximately two months in the difference
- two separate gaps were identified in the employment history of a staff

member, for example December 2016 to June 2017
- one staff member did not have their last employer reference on file as per requirement of the regulations.

A sample of rosters were reviewed over a two month period from August to part of September 2024. They indicated that there was sufficient staff in place at the time of the inspection to meet the assessed needs of the residents. There was a planned and an actual roster in place maintained by the person in charge.

The three staff on duty on the day of the inspection were found to be knowledgeable as to residents' needs and preferences.

From the questionnaires received and from speaking with some residents they communicated that the staff that worked in the centre were very nice.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix for all training completed and reviewed a sample of the certification for five training courses for all staff. This demonstrated to the inspector that staff received a suite of training in order for them to carry out their roles effectively. For example, staff were trained in areas, such as:

- fire safety and how to use an evacuation sheet
- safeguarding adults
- medication management
- first aid
- eating drinking and swallowing
- staff also received a range of training related to the area of infection prevention and control (IPC).

Staff had received additional training to support residents, for example staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

However, it was not clear to the inspector if staff received refresher training in the area of positive behaviour supports as from evidence provided to the inspector 12 staff last completed training in this area ranging from 2016 to 2018. One staff member commenced their post in July 2024 and were not scheduled to complete the training until October 2024. Due to the training not being facilitated in a timely manner, in the meantime this had the potential that the staff member would not have the skills required to de-escalate a situation if required.

The inspector also reviewed three staff supervision files, spoke with the person in charge and the centre lead. The inspector observed that the staff training and development policy did not describe the frequency at which supervision should

occur. The provider had arranged for the person in charge and the centre lead to receive training in supervision in order to facilitate staff supervision sessions. They communicated that the training recommended that supervision should occur every two months as deemed by best practice. The inspector observed that supervision was occurring between two months and in some cases six months apart. Notwithstanding that, from supervision sessions observed they were found to provide staff with opportunities to raise concerns if necessary.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that for the most part there were suitable governance and management systems in place at the time of this inspection. There was a defined management structure in the centre which consisted of a house lead (CNM1) and the person in charge who reported to the area manager. One staff member spoken with was familiar with the reporting structure of the centre and organisation.

The provider had carried out an annual review of the quality and safety of the service provided as per the regulations. There were arrangements for auditing of the centre carried out on the provider's behalf on a six-monthly basis which included resident and family consultation. There were other provider led and internal centre audits completed to assess the quality and safety of care and support provided to residents in the centre. This was to ensure that any identified issues would be rectified or escalated within in a timely manner.

For example, there were annual audits managed by the quality and standards team for the organisation in areas, such as:

- medication
- health and safety
- finance

From speaking with the person in charge and the CMN1, it was not made clear as to the frequency at which the audits were due to take place. The inspector was provided different time frames of either six months or annually. In some cases the inspector observed that, not all were occurring on a minimum annual basis, for example the last IPC audit completed in the centre that was evidenced to the inspector was from 2021.

Additionally, while the majority of actions from audits were found to be complete, some actions were found to be on-going and had surpassed the time frame assigned to them. For example, the provider's admission and discharge policy was still in draft format and had been on-going since 2022. Therefore, the inspector was not assured that all actions were completed within a timely manner. Additionally, the provider's audits had not identified the issues observed by the inspector on this inspection.

From a review of the most recent team meetings minutes since January 2024, they demonstrated that they were taking place on average monthly and that incidents were reviewed for shared learning with the staff team.

Judgment: Substantially compliant

Quality and safety

Overall, the inspection found that the residents were receiving a good standard of care that met their needs and facilitated the residents to have a pleasant respite break. However, as previously stated some improvements were required in relation to individual assessment and personal plans and positive behaviour supports.

Residents were being supported with their identified support and emotional needs. However, some improvements were required to ensure plans contained all applicable information, to ensure an assessment of need was completed for all residents and to ensure that where applicable that goals are progressed during respite stays.

The inspector reviewed restrictive practices in use in the centre. For example, a monitor was in place at night for one resident to alert staff if they had a seizure. It was assessed as necessary for the safety of the resident and subject to review. However, not all restrictive practices in place were recognised at such and therefore not subject to review to ensure they were necessary.

From a review of the safeguarding arrangements, the provider had arrangements in place to protect residents from the risk of abuse, for example staff had received training in adult safeguarding.

The inspector observed from a review of documentation and from speaking with a staff member that, residents were being communicated with using their preferred communication methods. Additionally, residents were supported to have an enjoyable respite stay in line with their personal preferences.

The inspector observed the premises to be tidy and for the most part clean and in a good state of repair. Some minor areas were identified for improvement, for example to ensure all areas could be cleaned effectively.

There were systems were in place to manage and mitigate risk and keep residents safe in the centre. For example, there was an organisational risk management policy in place. Additionally, there were suitable fire safety management systems in place, which were kept under ongoing review. For example, the fire detection and alert system was serviced quarterly by an external professional.

Regulation 10: Communication

Communication was sufficiently facilitated for residents in accordance with their needs and preferences. For example, the inspector observed pictures were available to support residents to make informed choices regarding meal and activity options. The majority of the staff team were trained in simplified sign language and the inspector observed one staff member use sign language when communicating with a resident.

From a sample of three residents' communication documentation, the inspector observed that they had clear documented communication needs as to how the person may communicate. In addition, the inspector observed that some residents had received an assessment from speech and language therapist (SLT) as to how best to communicate with them.

A staff member spoken with was clear as to how residents communicated and how staff should communicate with them.

In addition, the inspector observed that the residents had access to the televisions, phones and Internet within the centre.

Judgment: Compliant

Regulation 13: General welfare and development

The person in charge had ensured that residents had access to opportunities for leisure and recreation while on their respite breaks. For example, the inspector observed jigsaws, DVDs, board games and computer games available for residents to use in the centre.

The inspector reviewed the daily notes for the last two respite breaks for three residents. They demonstrated residents' daily recreation and activities that they participated in. From the sample reviewed, residents were observed to participate in activities based on their interests. For example, they were observed to go out for lunch or dinner, they had participated in an art project for a summer fair, they had attended a leisure centre, and went to the beach.

Some residents went fruit picking during the summer and made jam with the fruit they picked. They brought some jam home for their families for them to try some.

Judgment: Compliant

Regulation 17: Premises

The inspector observed the premises to have all the facilities of Schedule 6 of the regulations available for residents use. For example, rooms were of a suitable size and layout suitable for the needs of residents and residents had access to cooking and laundry facilities.

Generally, the premises was found to be in a state of good repair and it was found to be clean. The inspector observed that some minor areas required repair or replacement in order to ensure they could be appropriately cleaned and a small number of areas required resealing. They included:

- the surface of the sink plughole of the downstairs water closet (WC) was worn
- some small areas of the surface of some kitchen presses had peeled and
- the window surrounds of three bathrooms had mildew.

The person in charge arranged for the mildew to be cleaned on the day of the inspection; however, the stain remained of the mildew, They communicated that going forward the external cleaner would observe for and clean any mildew on a weekly basis. The organisation's Chief Executive Officer (CEO) confirmed to the inspector that the seals around the window, the plughole and the kitchen presses would all be completed by 30 September 2024 or sooner if possible depending on materials required.

There was adequate space for the residents, for example there was an open plan kitchen, dining and living room area and two separate sitting rooms.

Each resident had their own bedroom while on their respite break and had adequate storage facilities for any personal items they wanted to bring with them for their stay.

Judgment: Compliant

Regulation 26: Risk management procedures

There were adequate systems in place to manage and mitigate risk and keep residents safe in the centre. For example, there was a policy on risk management available.

A risk register was maintained for the designated centre which was reflective of the presenting risks. Risks specific to individuals, such as choking risks or slips, trips and falls, had been assessed and control measures identified.

On review of other arrangements in place to meet the requirements of this

regulation, the inspector observed that the centre's boiler and equipment used to support residents, for example a hoist had received an annual service. The centre's vehicle was found to be taxed, serviced and was not yet due for the national car test (NCT) due to its age.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and firefighting equipment, each of which was regularly serviced.

The inspector reviewed a sample of three of the residents' personal emergency evacuation plans (PEEP). They were observed to be up to date and provided clear information to guide staff regarding any evacuation supports required. Periodic fire evacuation drills were taking place. The inspector reviewed the documentation of the last seven drills and they included an hours of darkness drill.

Three fire containment doors were observed to have larger than recommended gaps where the door met the frame or where two fire doors met. That had to potential to limit the door's ability to contain fire and smoke if required. The provider arranged for these to be adjusted on the day with evidence shown to the inspector.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector found that for the most part the provider had appropriate arrangements in place to meet the requirements of this regulation. There were personal plans in place for any identified needs with clear information as to supports required. For example, some residents were on modified diets or had epilepsy and there were corresponding plans in place to guide staff on supports residents required. Plans were reviewed at intervals for effectiveness. The person in charge and a staff member spoken with were aware of residents' specific needs in those area.

However, one epilepsy care plan was not reviewed after a neurology review and in light of the direction given by the neurologist. The plan did not contain all applicable information guiding staff that only one dose of emergency medication was to be administered when in fact two doses could be given. This had the potential for staff not to provide care to residents in line with professional advice which could impact on their health.

In addition, while the centre staff appeared to know the residents well, the provider had not ensured that there was a comprehensive assessment of the health, personal and social care needs of each resident carried out prior to admission and annually there after. Assessments were carried out informally from talking to families or what was known from the day service as the respite users attended day programmes run by the provider. The centre staff updated care plans as they got to know the residents further. The quality manager confirmed to the inspector that the provider had an assessment of need document in draft format that was currently being worked on. The hope was that the new assessment would be rolled out to the service in the coming months. However, at the time of this inspection it was not in place.

Furthermore, from a sample of two residents' goals, while residents were being supported with goal setting through their day service programme it was not clear to the inspector, what part the respite centre was playing to support residents to achieve their goals. For example, one resident had a goal to be supported to learn to brush their own hair and the goal was due for completion in January 2023 and was recorded as not yet completed. The person in charge communicated that they weren't sure why the goal was not completed or what supports the respite centre were providing in supporting the resident to achieve that goal.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector reviewed the arrangements for positive behavioural support. They found from a review of two residents' files and speaking with a staff member, that the provider had for the most part suitable arrangements in place for oversight and for supporting residents in this area.

The registered provider had systems in place to ensure that where restrictive practices were used, for example an video monitor at night for someone with epilepsy, that there was governance over these practices to ensure that they were necessary. For example, the restrictive practice in place was recommended by an occupational therapist and was reviewed periodically. However, the inspector observed that not all restrictive practices in place were identified as such. For example, sharp knives were locked away and the inspector observed some window restrictors and a door restrictor was in place. Therefore, the inspector was not assured that all restrictive practices in place had clear rationale for their use to ensure that they were required and were the least restrictive for the shortest duration.

Residents were supported with behaviours that may cause distress to themselves or others. Where applicable, residents had a positive behavioural support plan which was reviewed by a senior clinical psychologist. A staff member spoken with demonstrated they were familiar with the steps to take to support the residents if

required.

Judgment: Substantially compliant

Regulation 8: Protection

There were adequate systems in place to safeguard residents. For example, there was an organisational adult safeguarding policy in place and staff were trained in adult safeguarding.

One staff spoken with was clear on what to do in the event of a safeguarding concern. Potential safeguarding risks were reported to the relevant statutory agency and a safeguarding plan was put in place in order to minimise the chances of further safeguarding risks to the residents. The inspector saw evidence of safeguarding measures being reviewed to ensure appropriate steps had been taken and if they were working.

From a sample of two residents' finance documentation, the inspector observed that their finances were checked by staff at both the start and end of a resident's respite break and anytime money was spent to ensure their money was accounted for and safeguarded.

The inspector also reviewed a sample of three intimate care plans. They guided staff as to supports residents required.

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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Prosper Fingal Residential Respite Service 1 OSV-0001860

Inspection ID: MON-0036406

Date of inspection: 03/09/2024

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: Gaps in information and documentation specified in Schedule 2 of S.I. No. 367 of 2013 will be obtained in respect of residential respite staff.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: a) Refresher training in positive behaviour support will be delivered to existing residential respite staff who have not had positive behaviour support training in the last 24 months. b) New residential respite staff will receive a briefing on positive behaviour support at initial induction and training in positive behaviour support within 4-6 weeks of commencing employment. c) The Prosper Training, Development and Education Policy will be updated to include frequency at which staff supervision should occur for residential respite staff. d) Staff supervision will occur in accordance with the frequency set out in the Prosper Training, Development and Education Policy.	
Regulation 23: Governance and	Substantially Compliant

management	
Outline how you are going to come into compliance with Regulation 23: Governance and management: a) The frequency of different audits will be made clear to the PIC. b) Audits will be planned to take place at a minimum annually. c) IPC audits will be added to the internal audit schedule. d) Timeframes for completion of actions arising from audit will be monitored bi-monthly and will be escalated to the Area Manager if timeframes are surpassed.	
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: (a)The Assessment of Need currently in draft will be completed and implemented within the residential respite service. (b) Residential respite staff will be instructed (1) to review each resident's Assessment of Need as required, but at a minimum annually and (2) to evidence same on the client data management system. (c) The day service key workers will be instructed (1) to liaise more closely with residential respite staff about supporting resident personal goals and (2) to evidence same on the client data management system. (d) The day service key worker will be instructed (1) to amend resident's epilepsy care plan in respect of neurology review and (2) to inform the residential respite service of updates.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The practice of (1) locking away knives, (2) use of window restrictors and (3) use of door restrictor will be reviewed and responded to in accordance with the Prosper Restrictive Practices 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 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	31/12/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	15/10/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/10/2024

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 05(1)(a)	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 prior to admission to the designated centre.	Substantially Compliant	Yellow	30/11/2024
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	30/11/2024
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal	Substantially Compliant	Yellow	31/10/2024

	plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	31/10/2024
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	15/11/2024
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	15/11/2024

Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	15/11/2024