Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Wyattville
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	13 September 2018
Centre ID:	OSV-0002893
Fieldwork ID:	MON-0021733

About the designated centre

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

The designated centre is based in a suburban area of South County Dublin and is comprised of one community based residential unit and one community based respite unit. Residential services are provided to four adults, while respite services are provided for up to five adults at one time from a respite use group of 80. The residential service is provided through a four bedroom detached house while the respite service is provided through a four bedroom terraced house. While residential services are provided on a 24 hour basis over 365 days, respite services are provided on a 24 hour basis across 340 days of the year. There is a person in charge, two social care leaders, and staff teams in place in the centre to support residents and respite users.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

To prepare for this inspection the inspector or 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
13 September 2018	09:15hrs to 19:00hrs	Thomas Hogan	Lead

Views of people who use the service

The inspector met with four individuals availing of the services and spoke in detail with one resident. Some of the residents met with by the inspector were unable to communicate verbally and the inspector spent time observing the care and support being delivered to these individuals. Residents appeared to be content and were observed to have plans in place for daily activities which were being undertaken at the time of inspection. The resident spoken in detail with by the inspector communicated that they were satisfied with the services they received and felt safe while in the centre.

The inspector met with a family member of an individual availing of the services of the centre and concerns relating to insufficient resources emerged from the discussions held. The family member expressed concerns regarding this matter which included limited availability of respite services due to complex support needs.

In addition to meeting with residents, observing the delivery of care and support, and speaking with a family member, the inspectors reviewed four completed questionnaires regarding issues including satisfaction with the service provided, accommodation, meal time experience, visitation, resident rights, activities, care and support, staffing, and complaints. Overall, the review of the questionnaires found that respondents were satisfied with the services provided, however, emerging themes included dissatisfaction with access to outdoor areas, availability of private spaces, and the arrangements in place for storing personal possessions of residents.

Capacity and capability

Overall, the inspector found that the services provided were of a good standard and were safe. There were appropriate governance and management structures in place and the staff team were observed to be responsive to the needs of residents in a timely manner and interacted in a kind and respectful manner throughout the period of inspection. Eight regulations were inspected against relating to *capacity and capability* and the inspector found mixed levels of compliance. Areas which were identified as requiring attention in order to ensure improved regulatory compliance included staff training and supervision, resourcing the centre appropriately to meet the needs of respite users, the self-identification of areas of concern, and the area of admissions and written contracts of care.

The inspector found that the person in charge in the centre at the time of inspection was very knowledgeable of the regulations and legislation and demonstrated a responsive approach to rectifying areas of non-compliance identified. The person in

charge was employed in a full-time capacity and was supported in their role by two full-time supernumerary social care leaders each of whom had responsibility for one unit of the centre. The registered provider informed the inspector that there were plans in place for the departure of the person in charge from the centre and outlined plans to replace them in a temporary manner while a recruitment campaign took place for a permanent replacement.

A review of staffing arrangements found that there were sufficient numbers of staff with the necessary experience and qualifications employed to meet the identified needs of residents in one unit of the centre. Improvements were required in relation to the availability of sufficient staffing resources in a unit providing respite services. The inspector observed staff member interactions with residents to be timely and respectful throughout the period of inspection and in discussions held with staff members the inspector found staff to speak of residents in a manner which upheld values of respect and dignity. While there was a staff duty roster in place in the centre, the inspector found that planned and actual duty rosters were not satisfactorily maintained. Duty rosters did not include the name of the centre or the time frame for which the record applied and a colour coding system used within the duty roster was not explained in a key. A sample of three staff files reviewed found that all required information as set out in Schedule 2 of the regulations were contained within.

The inspector reviewed staff training records and found that there were some gaps in areas of mandatory training. The person in charge outlined that a plan was in place for addressing the identified deficits in staff training and that this would be fully completed by 03 October 2018. 96 per cent of staff had completed manual handling training, 91 per cent had completed fire safety training, 83 per cent had completed training in the safe administration of medication, 65 per cent had completed training in break away techniques, 56 per cent had completed training in epilepsy, and 56 per cent had completed training in dysphagia. All staff members were found to have completed training in safeguarding vulnerable persons.

Formal staff supervision records were reviewed by the inspector and it was found that one-to-one supervision meetings were being held with staff members on a regular basis in line with organisational policy on this matter. The inspector found, however, that the content of these supervision meetings focused on specific tasks and areas such as annual leave rather than on enhancing the care and support provided to residents. Informal supervision took the form of social care leaders working in a full-time supernumerary capacity in both units of the designated centre and providing support to staff members on a day-to-day basis. In addition, the inspector found that team meetings were taking place on a regular basis in the centre.

In reviewing governance and management arrangements, the inspector found that the centre was not adequately resourced to ensure the effective delivery of care and support to all respite users. In the respite unit of the centre, there was evidence available which demonstrated that services were withheld to some respite users and in some instances reduced and limited to respite users with complex needs. Despite this finding, the inspector found that the residential service area of the centre was

appropriately resourced to ensure care and support was provided in line with the centre's statement of purpose. Both the person in charge and registered provider had been aware of the matter of insufficient resources prior to the inspection and had taken action to address the matter including seeking additional resources from the funding authority, however, this had not resolved the matter. With regards to other areas relating to governance and management, the inspector found that there was a clearly defined management structure in place and there were appropriate systems in place to ensure that services provided were safe and effectively monitored. Annual reviews had been completed in the centre and these had been made available in accessible formats to stakeholders. In addition, there was evidence of unannounced six monthly visits to the centre by the registered provider or persons on behalf of the registered provider. Reports from both the annual review and six monthly unannounced visits were found to be comprehensive in nature, however, it was noted that in these internal audits areas of compliance were incorrectly identified. One example of this involves the area of fire containment being identified as compliant by the registered provider which is in contrast to the finding of the inspector at the time of inspection.

A review of admission, discharges and transfers to and from the centre was completed and it was found that none had taken place to the residential unit of the centre since the time of the last inspection. In the case of the respite service unit, a number of admissions had taken place. It was found that in the cases of some recent admissions to this service the process was not satisfactory and resulted in poor outcomes for respite users. There was evidence available which demonstrated that respite users were admitted to the centre despite it not being able to support their needs appropriately. Both new admissions to the service and previous respite users were impacted negatively as a result due to compatibility issues and subsequent withdrawal of services for some individuals. A review of written agreements in place for individuals availing of the service found that in the case of the residential service, written agreements did not clearly outline the services to be provided or the charges to be incurred by residents. In addition, it was not clear if residents would incur a charge for accessing 'external clinicians', or if bedrooms were furnished by the provider or at the cost of the resident. In the case of the respite service, the written agreements failed to include matters such as the terms of accessing the service, the services to be provided and the fees to be charged.

The inspector reviewed the statement of purpose (dated June 2018) in place in the centre at the time of inspection and found that several areas of this document did not comply with requirements set out in the regulations. Detailed feedback was outlined on this matter to the person in charge and an opportunity to revise and update the statement of purpose was provided. A revised statement of purpose (dated September 2018) was submitted to the inspector post inspection and was found to meet the requirements of the regulations.

A review of the complaints procedure found that the registered provider had established and implemented effective systems to address and resolve issues raised by residents or their representatives. There were 15 complaints made in the centre in 2018 and the inspector found that 13 of these had been satisfactorily resolved

and closed off by the provider. There was evidence which demonstrated that residents were encouraged and supported to express concerns through the complaints procedure. There was an easy read complaints procedure on display and the process for making a complaint was discussed at resident forums. Information regarding accessing advocacy services was also on display in the centre and a complaints policy (dated April 2016) was found to be in place. The person in charge maintained a comprehensive register of all complaints made which captured the current status of each complaint and measures taken to date to reach a resolution.

Regulation 14: Persons in charge

The inspector found that the person in charge in the centre at the time of inspection was very knowledgeable of the regulations and legislation and demonstrated a responsive approach to rectifying areas of non-compliance identified.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that planned and actual duty rosters were not satisfactorily maintained in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed staff training records and found that deficits existed in six of seven mandatory training areas. While formal one-to-one supervision meetings were held with staff on a regular basis, the content of these meetings were found to relate to specific tasks and areas such as annual leave.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider was found to have a contract in place which insured against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

In one area of the centre there were insufficient resources available to ensure the effective delivery of care and support. The needs of respite users were not met in this unit due to insufficient accommodations, insufficient staffing levels and the absence of appropriate environment to support persons with more complex needs. In addition, the inspector found that the self-identification of areas of non-compliance and concerns through internal auditing mechanisms required development and improvement.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

It was found that recent admissions to the respite service of the centre were not satisfactorily managed and resulted in poor outcomes for respite users. Evidence demonstrated that residents were admitted to the centre despite it not being able to support their needs appropriately. Both new admissions to the service and previous respite users were impacted negatively as a result due to compatibility issues and subsequent withdrawal of services for some individuals. In addition, written agreements in place did not include matters such as terms for accessing the services of the centre, the services to be provided, and the costs to be incurred by residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

A revised statement of purpose (dated September 2018) was submitted to the inspector post inspection and was found to meet the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were effective systems in place for the management of complaints in the centre.

Judgment: Compliant

Quality and safety

The inspector found that while regulations
were identified which required improvements, residents availing of the services enjoyed a good quality of life. There was evidence available which demonstrated that a person-centred service was provided and residents were supported to exercise their rights. Residents were supported where possible to develop and maintain personal relationships and links with the community and to access activities and build life long skills. Despite this, mixed levels of compliance were found across five of the six regulations inspected against relating to *quality and safety.* Considerable improvements were identified as being required in order for the registered provider to ensure compliance was obtained in these regulations. Non-compliances were found in the areas of premises of the centre, risk management arrangements, fire precautions, medication management, and individual assessments and personal plans. The regulation relating to protection was found to be in full compliance by the inspector.

The inspector found that the premises of the centre in some areas required painting and decorating, however, overall the centre was clean, homely and appeared to be in a good state of repair. In one unit of the centre three bedrooms and a hallway area were identified as requiring painting and decorating. Concerns identified relating to the premises of the centre focused on the suitability of the centre for a number of respite users and the requirement of respite users to share a bedroom while availing of services. The inspector found that the unit which was used to provide respite services was not suitable in its design and layout to meet the needs of some respite users. While there were four bedrooms in this unit, one of the rooms was used to accommodate two residents for each respite period and the inspector found this arrangement did not promote privacy and dignity. In this unit it was found that five respite users were accommodated at any time and were supported by a sleep over or waking night staff and on occasions a second staff support. The inspector found that the general communal accommodation of this unit was not sufficient to allow for the provision of good quality and safe care and support to this number of respite users.

A review of risk management policy in place in the centre (dated July 2018) found that all specifically required sections of the policy as outlined by the regulations were not included. The policy did not outline the arrangements for the identification, recording and investigation of and learning from serious incidents or adverse events involving residents; and the arrangements in place to ensure that risk control

measures were proportional to risks identified and that any adverse impact such measures might have on residents' quality of life had been considered was also not included. There was a risk register maintained in the centre and while the inspector found this to be comprehensive in nature, some identified risks were not appropriately and consistently assessed. For example, in one unit of the centre where there were insufficient fire containment measures present the risk register stated that the risk was rated at three out of 25 and as a result was not a priority risk in the centre. In addition, the inspector found that the risk of residents potentially experiencing abuse had not been assessed. A review of incident, accident and near miss records maintained in the centre found that 26 incidents had been logged in 2018 to date. The person in charge demonstrated appropriate oversight and management of incidents and there was evidence available of regular analysis of incident records. Appropriate follow up action was found to have been taken in response to incidents which had occurred in the centre.

The inspector found that there were insufficient measures in place in the centre for the containment of fire. Where there were measures in place, these were found not to be in working order in some instances. Emergency lighting was not present in some areas of the centre which formed emergency escape routes. There was evidence available to confirm the regular service and maintenance of the fire detection and alarm system, emergency lighting, and fire extinguishers. A review of fire drill records highlighted that there were reoccurring difficulties with evacuating all residents from the centre during staged fire scenarios. The inspector found that plans in place at the time of inspection did not satisfactorily address these difficulties or outline how to overcome them in the event of a fire or emergency. However, the person in charge detailed actions which were underway to complete this which included inputs from allied health professionals and the collection of data to inform a revised plan.

A review of medication management systems identified several areas which required improvement. These included staff members being unable to confirm that medication contained in the medication cabinet was within expiry dates, PRN medication (medication administered as the need arises) protocols not signed by a prescribing practitioner, contradictory information contained on a prescription and emergency medication protocol, and the lack of clarity in the time to be taken between the administrations of PRN medication. In addition, the inspector found that there was no system in place for the disposal or return of out-of-date, spoiled, or discontinued medication. The person in charge confirmed that risk and capacity assessments had not been completed for residents with regards to the self-administration of medication. Staff members spoken with were found to be aware of the appropriate actions to take in response to a medication error.

The inspector found that while there were assessments completed of residents' needs, these were not comprehensive in nature and did not include areas such as safeguarding, staffing support requirements, fire safety, and risk for example. While there were some personal plans in place, not all needs identified through the assessment process were addressed through the creation of a support plans. In the case of respite users, there were no plans in place to address needs identified through a "respite assessment" completed. In addition, the inspector found that

where plans were in place, these were limited in nature and did not provide guidance for the reader on how to support residents with the specific need. There was an absence of evidence to demonstrate that there was allied health professional input during the reviews of personal plans, and that the review of plans included an assessment of their effectiveness.

A review of incident, accident and near miss records found that 14 allegedly abusive incidents had occurred in the centre in 2018 to date. The inspector found that all incidents had been managed and followed up on appropriately in line with national policy. Staff members spoken with demonstrated appropriate awareness of the actions to take in response to an allegation, suspicion or witnessing abuse. The person in charge demonstrated appropriate oversight of safeguarding in the centre and was very knowledgeable of their responsibilities under national policy and legislation. Safeguarding plans were found to be in place to manage all incidents which had occurred.

Regulation 17: Premises

One unit which was used to provide respite services was not suitable in its design and layout to meet the needs of some respite users. There was insufficient communal accommodation in this unit to allow for the provision of good quality safe services to the number of respite users being supported. Some areas of the centre required painting and decorating.

Judgment: Not compliant

Regulation 26: Risk management procedures

A risk management policy in place in the centre was found not to contain two areas outlined in the regulations as being required. Measures were not in place to ensure the appropriate identification and assessment of risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were insufficient fire containment measures in place in the centre. Where there were measures in place for the containment of fire, these were found not to be in working order in some instances. Emergency lighting was not present in some areas of the centre which formed emergency escape routes. Plans were not in place to outline the supports required to successfully evacuate all residents in the event of

a fire or emergency.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that staff members were unable to confirm that medication contained in the medication cabinet was within expiry dates, PRN medication protocols were not signed by a prescribing practitioner, contradictory information was contained on a prescription and emergency medication protocol, and there was a lack of clarity in the time to be taken between the administrations of PRN medication. There was an absence of a system in place for the disposal or return of out-of-date, spoiled, or discontinued medication. Risk and capacity assessments had not been completed for residents with regards to the self-administration of medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Assessments of need were not comprehensive in nature and plans were not in place for all identified needs of residents. In addition, where there were plans in place, the inspector found that these did not appropriately guide staff practice. There was an absence of evidence to demonstrate that there was allied health professional input during the reviews of personal plans, and that the review of plans included an assessment of their effectiveness.

Judgment: Not compliant

Regulation 8: Protection

There were appropriate systems in place to ensure that safeguarding incidents were prevented where possible and responded to appropriately when they occurred.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Wyattville OSV-0002893

Inspection ID: MON-0021733

Date of inspection: 13/09/2018

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: Rosters that are maintained in the centre will now have the full date (timeframe per week), the centre name (along with location) and a key to explain coding of leave taken	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff in the centre are scheduled/planned to complete their mandatory training. This will take place over the remainder of the year. The agenda for Supervision with staff within the centre will be enhanced to include areas relating to Fire Precautions, Safeguarding and feedback from staff.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The audits carried out by PQSD on behalf of registered provider will from this year onwards be Regulation focused as opposed to Outcome based which will give for greater clarity to the compliance with regulations. An increase for 3 WTE frontline staffing has been approved for Respite location which will allow for enhanced respite services to those within the location and new admissions. An admission Protocol will be drafted for the Respite services to reflect the enhanced services provided and also to ensure that there is no admission where the current respite	

services are not suitable to meet needs of potential residents.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: Contracts of Care for those accessing Respite services within the centre, will be reviewed and amended to include all requirements of Regulation 24. The Contracts of Care for permanent residents in the centre will clearly include the schedule of fees to be charge to each resident. Admission criteria for Respite service users will be review to indicate the clear support needs that are catered for and the process for onward referral if necessary to meet their assessed needs.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1 bedroom will be painted, with the other bedroom being wiped clean of marks to the wall. In line with the new admission protocol for Respite services, the services provided will be clearly outlined and defined. Those referred who do not meet the criteria, or whose needs cannot be satisfactorily met in the current respite location, will be referred onwards for suitable services to meet their needs. The personal care facilities in the Respite location will be remodeled to enhance services provided in the location.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A new Risk Management Policy has been rolled out in the Designated Centre as of 12th October 2018. Training is scheduled for Managers in November with frontline staff being inducted in same. The Risk Assessments for the centre will be reviewed to ensure that the ratings are consistent with likelihood and impact of the risk within the cause and context of same. One Risk Register will be maintained for the Centre including all Risk Assessments that are in place.	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The Fire Register in the centre, which contains all the relevant details on the Fire Precautions is being reviewed and will be rolled out in the centre once complete.

Five fire door closings have been fixed since the inspection along with the installation of emergency lighting above the stairs in one location. Furthermore, four bulkhead lights are awaiting installation along with three fire doors in one location.

The Personal Emergency Evacuation Plans are currently being reviewed with the Multi-disciplinary team to get input into supporting the residents who are reluctant to evacuate. Furthermore, the input of the Clinical Safety Manager and Occupational Health and Safety Advisor will be noted to ensure that all areas have been explored and recorded to indicate the supports provided to the residents to facilitate safe evacuation from the centre in the event of a fire.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

A disposal container has be placed in one location indicating its use only for medications to be disposed of, so as to ensure that there is no confusion between this and regular medication.

All medications have the expiry date indicated on their packaging. Staff are now aware of same.

PRN protocol for the use of the emergency medication has been revised to ensure that it is in line with the Protocol for the Administration of emergency rescue medication.

Kardexes for use by Respite service users have been amended to include all relevant information required for the administration of PRN medications for all respite service users.

Evidence with regard to the risk and capacity of service users who self-administer medications while on a Respite stay will be maintained on their file in the location.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

The Comprehensive Assessment that is currently in place in the centre will be reviewed to include the areas recommended at inspection. The Comprehensive Assessment will also include a mechanism to indicate that the effectiveness of the plan has been reviewed, by whom and when.

In the Case of Respite service users, clear indication will be made of the link between the identified needs from the Respite Needs Assessment to the care plans that are in place.

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	19/10/2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/12/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	19/10/2018
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/01/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair	Substantially Compliant	Yellow	30/06/2019

	externally and internally.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	19/10/2018
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	19/10/2018
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	28/02/2018
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	31/01/2019
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care	Not Compliant	Orange	31/01/2019

	and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Not Compliant	Orange	31/01/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	19/10/2018
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	19/10/2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/01/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing	Not Compliant	Orange	31/01/2019

	fire precautions.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/01/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/03/2019
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.	Not Compliant	Orange	31/12/2018
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/12/2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	19/10/2018
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out	Not Compliant	Orange	19/10/2018

	of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Not Compliant	Orange	26/10/2018
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.	Not Compliant	Orange	31/03/2019
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2018
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 plan for	Not Compliant	Orange	31/12/2018

	the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 05(6)(a)	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 be multidisciplinary.	Not Compliant	Orange	31/03/2019
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Not Compliant	Orange	31/03/2019