Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Damien House Services
Name of provider:	Health Service Executive
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	16 April 2019
Centre ID:	OSV-0002442
Fieldwork ID:	MON-0026014

About the designated centre

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

The statement of purpose states that Damien House provides full-time long term care to twelve residents, male and female who are over 18 years old. Care is provided to residents who have a primary diagnosis of intellectual disability, physical disability, and behaviours that challenged. The centre comprises three houses and an apartment. One of the houses is a community based residence, and the other two houses and the apartment are campus based and are some distance from each other. The houses are described as 'secure' for 'risk management' reasons within the provider's statement of purpose.

The following information outlines some additional data on this centre.

Current registration end date:	17/01/2020
Number of residents on the date of inspection:	12

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
16 April 2019	09:00hrs to 18:30hrs	Noelene Dowling	Lead
16 April 2019	09:00hrs to 18:30hrs	Julie Pryce	Support

Views of people who use the service

The inspector met with four of the residents and spoke briefly with two. The residents communicated in their preferred manner and allowed the inspector to observe some of their routines. One resident helped staff make tea for inspectors and indicated that she was happy with her daily plans.They were going out for walks, and another was helping staff in the kitchen, playing board games, and being helped in a supportive manner with personal care. Inspectors observed that if residents indicated that they did not wish to participate in an activity this was respected. However, the inspectors observed that the residents had different experiences in the different houses. One resident immediately vocalised "no bus" to indicate he could not leave the centre. There were long periods observed with little interaction with staff in one house, and at one point the television was on but none of the residents were interested. Residents experience was not helped by the very un-homely and uncared for environment in one house.

Capacity and capability

This inspection was undertaken to ascertain the provider's actions following an inspection which took place in November 2018.There were 13 significant non-compliance's found by inspectors on this previous inspection. These were all related to the lack of adequate management and oversight in the centre which resulted in a negative impact on the residents welfare.

These non-compliances included healthcare referrals, access to activities for the residents, risk management, medicines management, suitable premises and safe fire management systems. Following the previous inspection, a cautionary meeting was held with the provider who was required to provide assurance to the Chief Inspector of the actions to be taken to address these areas of non compliance.

The provider had commenced works in a number of areas including fire safety systems, and some works had been undertaken on the unsuitable bathrooms and general maintenance of the houses. Satisfactory actions had also been taken on residents' personal and communication plans and healthcare personal plans. However, a number of actions had not yet been resolved and further actions were identified in relation to safeguarding, behaviour supports for residents and appropriate access to relevant mental health services for the residents.

Transport and improvements to the environment required significant improvement and funding for resolution. However, core factors such as safeguarding and direction of care practises are within the direct remit of the provider and local management team.

To this end, the management arrangements and systems were not effective to ensure the service was safe and could meet the needs of all of the residents.

The management structures include a director of nursing and a person in charge,with clinical nurse mangers in each of the units. However, although the post of person in charge is full-time, the post holder was only available three days per week. This limited the scope of oversight and direction available. Findings of this inspection showed a lack of clarity as to responsibilities which did not promote accountable governance or practice in this secure and complex service. This is demonstrated by the findings in the quality and safety section of this report.

Systems for oversight and quality improvements were not sufficient but areas for improvement had commenced. A detailed medicines management audit had been undertaken, with actions identified and completed as a result. However, other substantive matters such as critical incidents, safeguarding or the use of chemicals to manage behaviours were not included in these auditing systems to support learning and risk management.

The inspector reviewed the accident and incidents records and noted that there were delays in reviewing incidents, insufficient review and actions following incidents to avoid re-occurrences.

There was a high staff ratio available to the residents in this nurse led service. Some agency staff were used due to staff shortages but efforts were made to ensure consistency. Staff were suitably qualified for their posts. However, there were no staff supervision or performance management systems being implemented, to ensure staff carried out their professional responsibilities to the residents. Staff knowledge and understanding was varied, with some staff very familiar with the residents' needs but this was not consistent.

It was, however, apparent that the provider was aware of the issues and had taken steps to address them. A suitably qualified practice development specialist had been appointed to evaluate and implement changes to practices and this process had commenced. The provider also attended the preliminary feedback meeting and outlined measures to be considered in relation to the governance structures, areas of responsibility, more direct access to multidisciplinary services within the organisation and changes to the composition of the designated centre.

The provider was informed that these actions, and the continued implementation of the compliance plan issued by HIQA must be undertaken and sustained.

Regulation 14: Persons in charge

The person in charge, although technically full-time, was only available three days per week and this limited the scope of oversight and direction available in the centre.

Judgment: Not compliant

Regulation 15: Staffing

There were sufficient staff with the skill mix available to support the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were suitably qualified for their posts and mandatory training was current. However, there were no staff supervision or performance management systems being implemented, to ensure staff carried out their professional responsibilities to the residents.

Judgment: Not compliant

Regulation 23: Governance and management

The management arrangements and systems were not effective to ensure the service was safe and could meet the needs of all of the residents.There were insufficient quality assurance systems undertaken and no unannounced inspections or annual report which would inform changes to practice.

Judgment: Not compliant

Regulation 31: Notification of incidents

A significant safeguarding matter had not been reported to the Chief Inspector.

Judgment: Not compliant

Quality and safety

The quality of life and safety of the residents differed across the units which comprise the designated centre. In some instances, their care, activation and

recreational needs were well supported. For example, residents went swimming, had access to the local community, and went bowling. One resident did part-time supported work. Others preferred long walks and these activities were supported by 1:1 staffing where this was necessary. However, this was not a consistent finding and resident's access to such activities and their quality of life was impacted by the lack of reliable transport, and the lack of adequate clinical advice and behavioural supportive interventions to guide their care.

In response to the previous inspection, some residents had daily activation plans implemented and staff had commenced using pictorial images to support the residents with their routines, choices and communication. These activities were not undertaken with consistency however, for all of the residents. For example, arrangements had been made for a resident to attend a day service one day per week. This had not been available due to the lack of centre transport. Alternative transport arrangement made available by the person in charge were not used by staff, with no reasonable rational available for this.

Following a very serious incident in a vehicle in March 2017, a resident had been prevented from having external activity or access as it was deemed that no transport available was safe for this resident to use. This situation and the need for more suitable transport had been escalated to senior managers. However, inspectors were concerned at the lack of urgency in response to this situation. For example, consideration of alternatives to the residents already curtailed daily routines and the long term impact of this risk management strategy on the resident

Inspectors were also concerned at the lack of an adequate response to and recognition of a number of incidents where residents were impacted significantly or hurt, however inadvertently, by the behaviours of other residents. While some incidents had been considered safeguarding matters, others had not. The incidents that were taking place were found to have disrupted residents' routines to a significant extent. Inspectors were unable to ascertain any clarity as the frequency of these occurrences, which itself was of concern. From conversations with staff and a review of the safeguarding plans inspectors were not assured that such incidents were given due consideration to adequately protect the residents from re-occurrence.

There were detailed behavioural support plans available but no system for assessing their effectiveness, or if they were being adhered to. Staff were not aware of a significant change which had been made in one residents plan (as demonstrated to the inspectors). Given the complexity of some residents' needs and in some instances the environment they lived in, there was also insufficient access and review by mental health and psychology specialists. For example, one residents circumstances had not been clinically reviewed since 2017, despite significant concerns evident.

As required by the previous inspection, a register of restrictive practices and interventions was in the process of being devised. This would enable better oversight of all such interventions in place in the centre. A number of the restrictions had been reviewed and some were used only intermittently; for instance

the locking of a door to a secure apartment. Nonetheless, while there is a recognised need for security and safety in this centre, these standardised practices were not adequately reviewed taking the physical environment and its impact on the residents into account.

A number of residents had sensory assessments early in 2017. There were no additional interventions trialled or implemented following these. Inspectors were not assured that there was any urgency or planning in relation to these maters, which impacted on the individual resident's quality of life and mental well being.

Inspectors reviewed a sample of resident's financial records. At unit level, the records and cash tallied. However, there was a significant discrepancy noted in the monies which should have been available in a residents main cash account. While this had been noted by the providers auditors for some time, there was no evidence that this had been investigated or the monies returned to the residents' account. The provider was requested to address this as a matter of urgency on this inspection.

While the residents care was reviewed via multidisciplinary team, the process was not consistently sufficient to address the significant long-term and current needs of the residents. These reviews did not take account of their living environment, experience, lack of clinical assessment and therefore were not a comprehensive review of the residents' lives and care needs.

There was a significant improvement of evidence in access to healthcare assessments and such referrals were followed up on by the person in charge. There were also good support plans in place for all of the residents' healthcare needs.

The overall state of the premises and decor remained poor in two of the houses. A significant improvement had been made in the gardens of one of the houses which were now a pleasant outside space; the internal areas which required attention had not been addressed.

A new bathroom had been fitted into one of the campus based houses, but on the day of the inspection this was locked and not in use. It was reported by staff that there was a leak in this room.

The bathroom in the community house which was identified on the previous inspection as requiring refurbishment remained in an unsuitable and poor condition for use. The alternative bathroom in the house remained un-repaired, so that the broken shower doors meant that this was not an alternative facility for residents. Another shower room in a different house was in very unhygienic state.

There was evidence that basic maintenance was being addressed in a timelier manner.

Overall oversight and management of risk was not sufficiently robust as to ensure that risks throughout the centre were mitigated and monitored. There was still no adequate risk register in the centre implemented which could support the identification and management of the various risks which included clinical,

environmental and security.The director of nursing was compiling this register at the time of this inspection. Some environmental risks identified at the last inspection such as the hot water, had been mitigated. There was guidance in personal plans for staff in relation to some, but not all risks to the residents. For example, a resident at risk of falls did not have a sufficient management plan in place and an incident where a resident had been given the incorrect consistency of food was not dealt with appropriately despite the obvious risk.

The provider had addressed most of the fire safety works in the centre with the exception of one door which did not close effectively. Staff training was up-to- date. Fire drills had commenced in two houses, but not in one of the houses. However, there were no details in the records to indicate the time it had taken to evacuate, and the same exit was used each time. This did not provide sufficient assurance that the residents could be evacuated in an emergency situation.

Systems for the management of medicines were found to be satisfactory.

Overall, these findings indicate that there was a lack of direction of practice, strategic review of care, risk and incident management and guidance given the complexity of the resident's needs and the purpose of the centre.

Regulation 17: Premises

The overall sate of repair of the premises and decor remained poor in two of the houses, with unsuitable bathrooms facilities. The the environment in one house was stark and un-homely, which was not entirely due to need for the secure environment.

Judgment: Not compliant

Regulation 26: Risk management procedures

Oversight and management of risk was not sufficiently robust as to ensure that risks throughout the centre were mitigated, monitored and that there was a system for learning from incidents and accidents.

Conversely, actions taken in some instances did not demonstrate a proportionate response and therefore impacted adversely for a significant period of time on a resident.

Judgment: Not compliant

Regulation 27: Protection against infection

Procedures for the management of infections had improved.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had addressed most of the fire safety works in the centre with the exception of one door which did not close effectively but was in the process of being repaired. However, records available to inspectors showed that fire drills only took place in two of the houses. There were no details in the records to indicate the time these had taken, and the same exit was used each time. This did not provide sufficient assurance that the residents could be evacuated.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Systems for the management of medicines were satisfactory.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Reviews of care were not adequate in some instances, to ensure the residents needs were being met in the centre and there was insufficient access to clinical guidance by mental health and psychology assessment for the residents.

Some assessments undertaken, such as sensory assessments, were not included in the residents' personal plans and no interventions were implemented with the residents following them.

Residents social care needs and activities were impacted on by the lack of suitable transport and by lack of suitable interventions within one of the houses.

Judgment: Not compliant

Regulation 6: Health care

There was evidence that residents had access to healthcare assessments and reviews. Referrals were followed up on by the person in charge. There were also good support plans in place for all of the residents' healthcare needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were detailed behaviour support plans available to staff but there was no adequate system to ensure that these were followed and how effective they were for the residents.

Restrictive practices were not sufficiently reviewed and the impact on the residents quality of life considered.

Judgment: Not compliant

Regulation 8: Protection

Residents were not sufficiently protected from abusive interactions, some matters were not recognised as abusive and financial management systems were not safe in this regard.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Damien House Services OSV-0002442

Inspection ID: MON-0026014

Date of inspection: 16/04/2019

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The CNM2 working a 5 day week will register as the PIC of the Designated Centre. This person is supernumerary to the frontline roster. The Director of Nursing will register as the PPIM for the Designated Centre. All application to register as PIC and PPIM will be completed by June 14th 2019	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Supervision will be in the form of formal staff support meetings which will commence by 1st September with frontline staff. Prior to this the steps to be taken include • Information session to all stakeholders • Refresher training to be provided to managers who will provide the support • HSE Land Supervision awareness training to be undertaken by all staff and managers • 1:1 support meeting in place with local management team • Clinical supervision for the Director of Nursing has been agreed with a date to be rescheduled within the next 4 weeks	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The CNM2 working a 5 day week will register as the PIC as the designated Centre. This person is supernumerary to the frontline roster.
The Director of Nursing will register as the PPIM for the centre.
The other CNM2 and CNM1s will provide additional governance. Managers will be rostered both as frontline staff and supernumerary to provide supervision out of hours and leave cover leave .

All application to register as PIC and PPIM will be completed by June 14th 2019

To support the PIC in their oversight role the following are in place:
An audit plan implemented
QPS monthly meeting has the input from the QPS advisor where risks incidents outcomes of audits are reviewed.
Person Care Plan Working Group (PCPWG)

These are also being supported by the Practice Development Coordinator for Disability Services in their enhanced role in the centre.

In addition the vacant role of Assistant Director of Nursing has been approved for filling and is with the NRS for recruitment.
Once recruited this person will support the PIC and PPIM in providing support and oversight to the centre and other centres under their remit.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Ongoing training will be provided from the Safeguarding Team (SGT) and Quality and Patient Safety (QPS) Advisor in relation to incident reporting and identification of incidents that require notification.
All staff members and managers with responsibility for notifying incidents have been informed.
Standard agenda for all meetings includes discussion about safeguarding and compatibility between peers to increase understanding and vigilance towards peer to peer incidents and how to avoid these.
The Local Management team have met and are aware of incidents which require notification.
The PIC and PPIM now have access to the portal to ensure there is no delay in reporting

notifications.

The QPS Advisor is now in place, dedicated to Disability Services, to support with incident analysis and training in addition to investigation and incident follow up. The Safeguarding Team also provide support and training to the centre.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Maintenance and repair is ongoing. Maintenance requests are on the agenda for review at Team Meetings to ensure appropriate follow up on requests and that actions are completed. The process for tendering for work is being followed as necessary for all works being carried out.

An architects report for 3 of the buildings is now available to the service and has been reviewed on 27th May in order to develop a schedule of works for which the Provider representative is seeking to secure funding.
• The schedule of works will be categories under the headings of H&S and Infection Control and prioritised. The relevant costings will be submitted to the Chief Officer for funding.
• Due to the very limit resource Works will be carried out incrementally based on the risk presenting.
• The DON will liaise with the Local authority to ensure that all individuals will be on the housing list by 1st September

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk register populated on 16.05.19 with updated risk assessments has been reviewed with the QPS Advisor and Provider Representative on 21.05.19.
A system is in place regarding reporting and escalating incidents agreed at Provider Representative level.
Learning from incidents to be recorded at QPS meetings which take place monthly in the centre.
QPS advisor for Disability Services is in place and attends the QPS meetings locally each month.
The manager on call is identified to staff each week on the roster

A process map for the services in relation to incident reporting and review has been developed to assist all staff in ensure that appropriate review and follow up is adhered to as follows:.

• The PIC will review incidents on a weekly basis.
• All incidents will be reported to either the CNM on call by phone if they are not present on site at the time that they occur
• A SIMT (Serious Incident Management Team) will be convened in line with the Integrated Risk Management Framework
• This process will be tested for effectiveness by the Practice Development Co-ordinator over the coming months.

A Quality and Patient Safety Advisor for Disability Services in SECH has been appointed and has met with the Director of Nursing to identify the needs within the services.
They will support the services to put structures on the incident management processes and will also attend the Local Managers Meetings and Team Meetings as necessary to discuss incidents and support the documentation of learning from incidents and analysis of the incidents and all trends on a quarterly basis.
The QPS advisor will also provide staff training.

Incident review and learning is on the agenda of team meetings and management meetings in Damien House Services.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Technical Services have repaired the fire door that was causing concern.
• Any problems with fire doors or other equipment is immediately reported.
• PEEPS have been reviewed and updated.
• The document used to record the fire drills has been updated to include the start and completion time for the fire evacuation and also to record which exits are used.
• A record of fire drills is maintained in each house.
• Annual fire training is accessed by all staff

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:
A number of measures have been in place and these are reviewed to improve the quality of individual assessment and planning. The Interdisciplinary Team (IDT) continues to meet to review each person. Key workers attend these meetings

The Liaison Consultant Psychiatry service to the centre has been restored and individuals are being reviewed. A request for a second opinion in relation to the Mental Health needs and appropriate treatment and supports for one particular person have been sent to the Consultant Psychiatrist for an urgent appointment by their GP since they have commenced providing a service.

In conjunction with that referral an IDT is due to be held on June 26th to review this person and their file. IDT meetings have been held in relation to this person and their support needs in the absence of psychiatry support in addition to review by their GP for medical follow up. The IDT will outline more clearly the approach to be taken when delivering this person's support needs and the rationale for this approach.

Senior Clinical Psychology supports are in place through the IDT and also individual assessment and reports are being undertaken.

To support governance a Personal Plan Working group (PPWG) is being formed to put systems in place for the personal plan. The terms of reference for this group are that:
• The PPWG is the lead for this quality improvement initiative which will be aligned to statutory regulations for residential centres for people with intellectual disabilities, HIQA national standards for intellectual disability residential centres and personal plan guidance from the national quality improvement disability project, social care division.
• The PPWG will develop a document control system for all templates used with Damien House Regional Services that report, record, assess, evaluate, plan and audit residents care and support.
• The PPWG will develop a personal plan policy that describes all aspects of the structure of the files; the person centred planning process, filing and storage.
• The PPWG will develop an audit tool and an audit process (named auditors, time process, and structure of audit feedback meetings), to determine compliance with the policy and the quality of the person centred planning process.
• The PPWG will develop an information session for staff and agree a structure and process for ongoing staff support with implementation of the policy.
• The first meeting of this group is due to take place week commencing June 3rd

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Behaviour Support Plans are developed with the key workers and the CNSp Behaviour Support. Periodic Service reviews will commence on behavior support and safety plans that are in place in the designated centre, first review was conducted on the 21.05.2019. As part of this review the CNSp behaviour support will directly observe staff members

implementing the behaviour support plan. When investigating incidents the managers of the centre will check adherence to Behaviour Support Plans. Also Behaviour Support Plans will continue to be discussed at team meetings to review their effectiveness and suitability for use and also reviewed at the IDT meetings.

Interdisciplinary team meetings (IDTM) will be scheduled to ensure that each house within the designated Centre will have a minimum of one IDTM a month. During this meeting; the CNSp Behaviour support will be ensuring that the behaviour support plans are up to date and reviewed.

The restrictive procedure protocols will also be reviewed at these meetings on an ongoing basis. Dates scheduled for May include Damien House 13.05.2019, Sonas 21.05.2019, Apartment 29.05.2019, Avila 30.05.2019. Provisional dates have been set for June 2019. When it is identified that a Restrictive Practice Protocol is necessary as a result of a behaviour causing concern, further input from the CNSp will be required.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Ongoing training from the SGPT and QPS Advisor in relation to incidents and identification of abusive interactions for all staff and managers will take place across the services. PIC to review all incidents weekly to ensure that correct notification occurs. Safeguarding and compatibility of people who live together will also be discussed at team meetings and incident reviews. Where compatibility between people is identified as causing a concern, the persons' activity plans will reflect their need for individuality. Use of all available space is being reviewed to encourage individualised activities and interests both in the centre and away from it.

Where it has been identified that people would be best not continuing to share a home, it is incorporated into long term planning for the centre's accommodation plans in conjunction with the local authority.

Safeguarding plans have been reviewed taking into account the availability of transport, on 27.05.19, with alternative evening activities to be trialled in the absence of all transport vehicles being available.

A meeting was held on May 3rd to review financial records with General Manager from the Chief Officer's Office. Recommendations were made from this review with completion dates in May and July to ensure the historic issue identified is resolved and also that systems are streamlined to provide protection to individuals' money.

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	14/06/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Yellow	01/09/2019
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	31/12/2019
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre	Not Compliant	Orange	14/06/2019

	that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Yellow	24/05/2019
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	01/09/2019
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	31/05/2019

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	11/04/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	21/05/2019
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.	Substantially Compliant	Yellow	21/05/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected	Not Compliant	Orange	21/05/2019

	or confirmed, of abuse of any resident.			
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	31/08/2019
Regulation 05(6)(b)	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 conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	03/06/2019
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	Not Compliant	Orange	03/06/2019

	review shall assess the effectiveness of the plan.			
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.	Not Compliant	Orange	21/05/2019
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	21/05/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/07/2019
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.	Not Compliant	Orange	31/07/2019