Le Cheile, OSV-0004752, 30 July 2019

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:	Le Cheile
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	30 July 2019
Centre ID:	OSV-0004752
Fieldwork ID:	MON-0021541

About the designated centre

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

Le Chéile provides a full-time residential service for adults with a primary diagnosis of intellectual disability. The centre is registered to accommodate 24 people. The centre comprises four individual bungalows, one of which is divided into two apartments. These are located on the grounds of a campus on the outskirts of Limerick city. Two other designated centres are located on this campus. All parts of the centre are staffed during the day. Neither apartment is staffed overnight. The staff team comprises nurses and care assistants. The statement of purpose for the centre outlines that the day service for residents is provided mainly from home. Some residents access the day service on the campus or a community based day service at times.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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
30 July 2019	09:50hrs to 18:55hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

The inspector visited three of the four bungalows in the designated centre. During these visits all of the residents who lived there were at home. As one resident was unwell, their house was not visited during this inspection. The inspector met with 16 residents.

Some residents greeted or spoke briefly with the inspector, while others were observed as they engaged in activities of daily life, and interacted with each other and support staff. At the time of the visits residents were either preparing for, or being supported during, lunch.

In general, residents appeared at ease in their surroundings and comfortable with the support they were receiving from staff.

Capacity and capability

A number of issues were identified in the course of the inspection that indicated that the governance systems and management oversight in the centre required significant improvement.

Support provided in the centre was not always in line with the organisation's policies. A situation was described whereby a staff member had administered medication to a resident when off campus. This person had not received any training in the management of medication. The staff member and a member of the management team told the inspector that this practice was in line with the organisation's medication management policy, as a risk assessment had been conducted beforehand. Following the inspection, the inspector reviewed the policy and identified that this was not the case.

Additional oversight was required to ensure that the support provided in the service was consistent. There was evidence of actions taken by management to address identified issues. However, these improvements were not always put in place across the centre. For example, measures put in place to ensure better practice regarding the management and safeguarding of residents' finances were implemented in parts of the centre only.

It was explained to the inspector that staff who supported residents at night had a separate manager, who in turn reported to one of the persons participating in the management of the centre. This reporting structure was not reflected in the centre's statement of purpose. The inspector reviewed a folder in one house which contained information for staff who worked at night. The folder included

individualised night time support plans. A plan was not available for each resident. Other information included was no longer accurate and records indicated that the most recent meeting of the night staff was in 2017. These findings indicated poor oversight of the support provided to residents at night.

Staffing levels were not provided in line with the proposed roster and were heavily supplemented by people on employment schemes. The inspector asked for copies of the actual staff rota for two time periods selected at random. When compared with the planned rota, it was identified that in three of the four houses the staffing provided did not match the plan. There were a number of people working in the centre on placement as part of an employment scheme. This was not reflected on the rota or in the statement of purpose. Staff emphasised to the inspector the need for these additional supports to meet residents' needs. This was further evidenced by the provider appointing staff to fill these hours when those on placement were on leave. A member of staff told the inspector that the rostered nursing hours in one house were often reallocated to other houses on the campus.

There was a complaints log in each house and also a central complaints log maintained by the person in charge. When discussing one entry, the inspector was told that this issue was also the subject of a complaint made by a training professional. However, rather than in the complaints log, this additional complaint was documented in a risk assessment. The annual review included other complaints from residents that were also not recorded in the complaints log. It was difficult to get an overall sense of the management of complaints in the centre due to the various places information was stored. It was also noted that the recording system in place did not document whether complainants were satisfied or not with the actions taken on foot of their complaint, as is required by the regulations.

The regulations outline that the person in charge must notify the chief inspector of the occurrence of certain incidents. This was completed in a timely manner in the majority of cases. During the inspection it was identified that not all restrictive practices implemented in the centre had been recognised as such. As a result, not all restrictive procedures in the centre were notified, as is required.

Regulation 15: Staffing

Staffing was not always provided in line with the number and skill mix identified by the provider as appropriate to the number and assessed needs of residents in the centre.

The information and documents outlined in Schedule 2 of the regulations were not reviewed as part of this inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The designated centre was not adequately resourced. The management systems in place failed to ensure that the service provided was safe, consistent and appropriate to residents' needs.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not include an accurate description of the rooms in all parts of the centre. It also did not include the information set out in the certificate of registration.The organisational structure outlined in the statement of purpose did not accurately reflect the reporting structure in the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Some of the restrictive practices implemented in the centre were not identified as such. As a result their use was not notified to the chief inspector, as is required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The accessible format of the complaints procedure contained inaccurate information. It was not noted on the complaints log whether the complainant was satisfied with the actions taken on foot of the complaint.

Judgment: Substantially compliant

Quality and safety

While staff were knowledgeable about residents and positive relationships were evident, a number of areas required significant improvement to ensure that residents were provided with a safe, high quality service. An urgent compliance plan was requested regarding the findings relating to risk management procedures and fire precautions. These findings are outlined in more detail later in this report.

It was clear throughout the inspection that management and support staff knew each of the residents well. All interactions observed were warm and respectful. Many of the residents in the centre have significant physical and health support needs. Staff were knowledgeable about these needs and there was evidence to support good practice in ensuring healthcare provided was to a high standard. Residents also had access to specialist input regarding behaviours that challenge, as required.

The inspector reviewed a sample of residents' plans. Recent work had been done to improve the person centred planning processes in the centre and the benefits of this were evident in a plan reviewed by the inspector. This plan clearly documented meaningful goals for the person and the actions taken to date towards achieving these. There was evidence of review of individuals' plans by a multidisciplinary team. These included a review of restrictive practices where appropriate. Staff outlined a draft plan to reduce the use of one restriction. It was identified that some key support plans had not been updated in the last 12 months in line with the requirements of the regulations, or within the timeframes outlined in the centre's statement of purpose. In one case there had been a significant deterioration in a person's mobility since the guidelines regarding the use of their wheelchair were last revised.

A number of buildings on the campus are no longer in use and were in an evident state of disrepair. While efforts had been made to decorate, there was an obvious need for maintenance works in all parts of the centre. A number of surfaces were marked and paintwork was chipped throughout the centre. Although clean overall, food stains were observed on a wall in one house and on a ceiling in another. The bathroom facilities available to the majority of residents in two houses were of a poor standard; dust and cobwebs were also evident. Staff acknowledged that some bedrooms were not a suitable size for residents who use wheelchairs. Funding had been approved to convert three bedrooms into two larger ones. Equipment had been sourced for one resident which had a positive impact on the suitability of their bedroom.

It was observed during the inspection that laundry and the main meal of the day were delivered, rather than being prepared in residents' homes. A member of staff outlined to the inspector that one resident did not like this food and as a result their main meal was cooked in their home, in line with their preferences.

A number of risk assessments required review. The inspector reviewed a risk assessment completed regarding a resident, who may require emergency medication, leaving the campus with staff not trained in the administration of medication. This assessment required urgent review as the risk rating was not reflective of the information outlined and the control measures in the document

were not yet in place. An urgent compliance plan was requested regarding this finding.

When walking through the centre it was noted that, with the exception of one recently refurbished bedroom, fire doors were not installed. In two buildings bedrooms opened onto corridors which led to a large communal living area. To access one of the fire exits in each of these buildings required passing through two other rooms. The pathway to the assembly point for another house was incomplete. It was not clear that the means of escape in the centre were adequate. An alarm system and emergency lighting had recently been installed throughout the centre. Documentation regarding fire was reviewed for one house. Records indicated compliance with the sub-regulations regarding staff training and equipment maintenance. Staff were also completing daily and weekly fire safety checks. Each resident had a personal emergency evacuation plan. These plans detailed the high level of staff support required to evacuate each resident in the house. Fire evacuation drills had been completed. However in three out of the four evacuation reports reviewed, at least one resident had refused to leave the building. Drills did not reflect different staffing scenarios and use of various fire exits. It was not demonstrated that residents could be safely evacuated if there was an emergency. This finding prompted the request for an urgent compliance plan.

Regulation 17: Premises

All houses that comprise the centre required maintenance works. No facilities were available to residents to launder their clothes. Not all bedrooms for residents who use wheelchairs were of a suitable size with suitable storage facilities. The standard of the communal bathrooms in parts of the centre were poor. The standard of cleanliness in the centre required improvement.

Judgment: Not compliant

Regulation 18: Food and nutrition

Nutritious food was provided in the centre. Residents could choose the food they ate at mealtimes, however opportunities to buy, prepare and cook their own meals were limited. Staff demonstrated a good knowledge of residents' dietary needs and preferences.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk assessments relating to individuals who require emergency medication required urgent review. A number of risk assessments had not been reviewed within the timeframe specified.

Judgment: Not compliant

Regulation 28: Fire precautions

It was not clear that adequate means of escape were available in the centre. Additional arrangements for containing fires were required. The arrangements for evacuating all residents and bringing them to safe locations required review.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

While some personal plans had been reviewed recently it was identified that key support plans had not been reviewed in line the requirements of the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

There was evidence that residents' healthcare needs were well met in the centre. Staff spoken with were very familiar with residents' support needs and plans regarding their health. There was evidence of regular supported access to primary care, specialists and allied healthcare professionals, as 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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant

Compliance Plan for Le Cheile OSV-0004752

Inspection ID: MON-0021541

Date of inspection: 30/07/2019

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There is an agreed roster and skill mix for each bungalow in the designated centre. • Nursing levels are monitored daily. • Where nursing levels are under the agreed level there are risk assessments with agreed mitigations to manage this situation. • The recruitment of nursing and care staff is continual in order to ensure continuity of care and safety of residents. Since the inspection one nursing post have been filled and are due to commence training before start date. • Since the inspection the Person in Charge has updated the Statement of Purpose to reflect the number of Staff working in the centre and the CE employment workers who provide supports to individuals. • In total this represents 78 hours support per week across Le Cheile designated centre. • The CE staff are supervised by the CE coordinator in liaison with the Person in Charge and their roster is maintained in a folder in the communal manager's office base. • The statement of purpose and function will reflect the reporting relationship between the Night Managers and the Assistant Director of nursing.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • There is a plan to increase the number of Persons in Charge in the wider complex of Bawnmore which will reduce the size of this designated centre from 5 houses to 3 houses. • The recruitment of Persons in Charge has been advertised.	

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• Planned leave of ADON and PICS will be scheduled for future leave in order to ensure that the appropriate management levels are in place at all times.
• The intention is that there will be 5 CNM2 in place in Bawnmore by the 31st December 2019. This is subject to successful recruitment.
• The revised structure will strengthen the linkages between day and night management.
• Currently the management team including the PIC and Night managers meet on a weekly basis chaired by the ADON. The ADON meets the full night management including CNM2 and CNM1 once a quarter. All the meetings are chaired by the ADON.
• Learning from HIQA inspections, unannounced inspections, complaints, Accident/Incident reports are shared at these meetings and corrective action is taken.
• A daily email reporting system of residents is in place for to provide clearer communication and governance between both day and night.
• On a monthly basis the PIC attends a meeting of the wider PIC group where learnings from HIQA inspections, unannounced inspections and other relates areas are shared.
• The archiving of information on individuals supported was discussed at staff meetings and instruction was given that all old files were to be archived as per procedure included in the My Profile My Plan.
• The Person in Charge will monitor compliance with this direction as part of supervision.
• All risk assessments have been reviewed and updated. They will be reviewed quarterly as per procedure.
• A new fire safety committee has been established of which the PIC is a member as well as night managers.
• A new process for conducting fire drills is currently being developed with the advice of the fire safety engineer.
• A review of fire drills will form part of the oversight function of the fire safety committee of which the PIC is a member.
• The Medication policy is currently being updated and will reflect findings of the inspection. Once this has been finalised training will be provided to the team by person in charge.
• The file reviewed by the inspector has been removed and has been archived.
• Since the inspection the Person in Charge has updated the Statement of Purpose to reflect the number of Staff working in the centre and also to reflect the CE employment support staff who provide supports to individuals.
• The CE staff are supervised by the CE coordinator in liaison with the Person in Charge and their roster is maintained in a folder in communal mangers office base.
• Updated Statement of Purpose will be resubmitted by 4/10/19 following the updating of the floor plans.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Since the inspection the Person in Charge has updated the Statement of Purpose to

reflect the number of Staff working in the centre and the CE employment support staff who support service provision.
• The CE staff are supervised by the CE coordinator in liaison with the Person in Charge and their roster is maintained in a folder in communal manager's office base.
• The PIC has liaised with the Facilities manager to update floor plans as set out in Schedule 1 by 30/9/19.
• Updated SOPF will be returned to HIQA by 4th October 2019.
SOPF will be updated to reflect that night managers' report to the ADON.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Person in Charge has met with Clinical Nurse Specialist in Behaviour Support on the 27/08, 28/08 and the 03/09/19, to review Restrictive practices in Le Cheile.
• The Restrictive Practices identified in this report have been put in place and was discussed at MDT on the 18/09/2019.
• Notification of these Restrictions will be include in returns from Q3 due for return on 31st October 2019.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The Person in Charge placed a visible Easy to Read Complaints policy up in the hallway of each house in the Le Cheile designated centre.
• The Complaints procedure requires that the staff involved in the management of a complaint sign off to confirm that the complaint has been handled to the satisfaction of the complainant or that the complainant has been provided information and support to escalate the complaint as appropriate. The PIC will ensure that this takes place as part of their oversight of the centre.
• The complaints procedure requires the PIC to complete a summary of informal complaints in their area on a monthly basis. The PIC will use this review to ensure that the complaints procedure is being implemented appropriately.
• Complaints identified through other sources of engagement e.g. Annual Review Process will be channelled through the complaints procedure. This has been communicated to all PICs as part of monthly engagement between the provider and the persons in charge.
• The ADON, who is also the Complaints Officer for the designated centre will ensure that this procedure is followed appropriately for formal complaints and that records are

maintained to evidence this.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Brothers of Charity Services Ireland Limerick Region accepts that the standard of accommodation for residents of this centre is not to an acceptable standard. The buildings in Bawnmore were constructed in the 1970s and are of an institutional nature and require significant funding to maintain.
• The standard of premises including the sanitary conditions is a corporate risk and the funder has been advised of this risk through the Service Arrangement process. This will be formally raised at the next Service Arrangement meeting scheduled for November 2019
• A central laundry facility is on site to provide a laundry service for the persons supported as the houses do not have the infrastructure or space to accommodate equipment. Increasing electrical equipment in houses impact on the fire safety risk as advised by fire safety engineer.
• A system for prioritizing maintenance work in Bawnmore, which includes the Le Cheile designated centre, is being developed with the Facilities Manager.
• Facilities Manager met with Bawnmore Management Team on 8th August 2019 in order to agree priorities.
• The roll out of improvements such as the installation of individual safes to secure funds of individuals supported will be prioritized by the management team of which the PIC is a member and will be rolled out through the designated centre.
• A new cleaning company has been appointed, following a full tender process, and commenced work in this designated centre on 19th August 2019 with additional hours allocated. This represents a significant improvement in the cleaning service.
• A supervisor has also been allocated by the company in order to ensure a high standard of work and to carry out audits
• A deep clean was carried out to one house in the centre on the 17/08/19 following the inspection.
• Deep cleans will be rolled out in all bungalows by 31st December 2019.
• PICS will schedule a monthly meeting to review standards of cleaning with the cleaning company. Any issue of concern will be address or escalated as appropriate. The first meeting took place on Monday, 23rd September in order to ensure a high standard of cleaning service.
• Programme of works has been agreed to upgrade bedrooms within one bungalow that will improve accessibility and standard of accommodation for residents in the bungalow.
• Front door and ceiling has been painted in one house since the inspection.
In relation to resident's monies and installation of safes the PIC has progressed installing safes in all the designated centre. This will be completed by December 2019

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• Choice is offered to individuals support for their breakfast, snacks and evening meal and is prepared in each house of the designated centre.
• For the main meal a food menu for the week is discussed, where appropriate, with Individuals Supported each Sunday using visual aids to facilitate choice.
• Main meals are then ordered with the external catering company and meals are delivered fresh daily.
• In order to support choice and autonomy the general stores in the Centre was fully closed on 31st August. Individuals are now people supported to shop outside of the complex. This includes both shopping locally as well as online shopping.
• In relevant cases prescribed EDS plans by S&LT specific to individual needs are delivered by a specialist food company.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• Since the inspection the Person in Charge has liaised with the Head of Quality and Risk in relation to this risk assessment.
• All risk assessments have been reviewed and updated. They will be reviewed quarterly as per procedure.
• A revision of each Risk Assessment for each individual with a diagnosis of Epilepsy has been completed and put in place.
• Emergency Protocol in place for one house for the administration of rescue medication until the finalized medication policy is approved by the Policy Review Group.
• In the meantime, where the resident requires to leave the campus he will be accompanied by a nurse.
• 39 Healthcare assistants have been trained in Epilepsy Awareness and Administration of Bucculam and they will be in a position to administer rescue medicine once protocol is in place.
• Since the Inspection the Person in Charge has reviewed and up-dated Generic Risks with ADON on the 20/08/19.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Brothers of Charity Services Ireland Limerick Region (BOCSILR) take the issue of fire safety for the people we support very seriously. In order to assure the best possible fire safety approach, the BOCSILR has engaged with a Fire Safety Engineer.

• Following the inspection and in a further effort to be proactive in respect of fire safety the following actions are also taking place: -

o A new Fire Safety committee has been established since the 16th August and has a Fire Safety Engineer as a member in order to advise and support the management team.
o Night time Fire Drills took place on 23rd, 24th and 25th August in all houses based on advice from the Fire Safety engineer as part of discussion of the Fire Safety Committee. These night drills were simulated. A review of how we conduct fire drills is currently in process and the profile of all individuals supported in the designated centre has been sent to the fire safety engineer in order to inform this process.
o Meetings between the DOS, ADON, PIC and Fire Safety engineer with residential day staff took place on 17th and 24th of September in order to emphasise the importance of fire drills and fire safety protocols and the focus on fire prevention.
o All egress plans have been reviewed and updated and will be reviewed on an ongoing basis as part of the learning from fire drills.
o Fire Marshall training for first responders took place on 25th September 2019.
o Fire emergency protocol and first responder protocol has been updated by the fire safety engineer and has been communicated to staff as part of engagement on fire safety.
o Similar meetings with night staff took place on the 18th and 25th September.
o Electrical survey has commenced on 16th September and necessary upgrades will be actioned as a priority.
o Electrical checks by staff are currently being developed with the support of the fire safety engineer. Once finalised these checks will be carried out twice during the night and once during the day in order to mitigate fire safety risk.
o An interim fire safety check at night was implemented in all staffed houses following the inspection.

• HSE Fire Safety survey took place in the designated centre between the 28th and 30th August with a view to making recommendations in respect of further fire safety upgrade works.

• A meeting with the Funder and representatives from both the BOCSI and the Funder took place 6th September 2019. Actions from this meeting are currently being agreed. Draft report to be issued to BOCSI by 30th September 2019. Final report will be issued by 31st October 2019.

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: • Since the Inspection the person all plans of care have been reviewed and up-dated where applicable reflecting the personal needs of each Individual Supported. MDT have consulted as required.	

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	04/10/2019
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	15/09/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Substantially Compliant	Yellow	31/12/2021

	the aims and objectives of the service and the number and needs of residents.			
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 externally and internally.	Not Compliant	Orange	31/12/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/12/2019
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	31/12/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out	Not Compliant	Orange	31/12/2019

	in Schedule 6.			
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Substantially Compliant	Yellow	31/08/2019
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	04/10/2019
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	31/12/2019
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	Not Compliant	Red	07/08/2019

	emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/12/2020
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/12/2020
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/12/2020
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	Red	31/12/2020
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	04/10/2019
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each	Not Compliant	Orange	31/10/2019

	quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.	Substantially Compliant	Yellow	31/08/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not	Substantially Compliant	Yellow	10/09/2019

	the resident was satisfied.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	06/09/2019