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Leeside, OSV-0003319, 30 June 2020

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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:	Leeside
Name of provider:	Health Service Executive
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	30 June 2020
Centre ID:	OSV-0003319
Fieldwork ID:	MON-0029602

About the designated centre

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

In the statement of purpose the provider outlines that the Health Service Executive, Leeside, provides full-time residential care for three adult males with intellectual disabilities and significant challenging behaviours. This is a secure, high-support service, with a high ratio of social care staff. Nursing oversight is available from the wider organisation as needed. The premises is a dormer style detached house on its own grounds. Each resident has their own bedroom and en-suite bathroom, and share a communal kitchen, recreation and living area. There is a secure easily accessible garden. There is a commitment to the process of maximising the health and social well being of each service user, where individual choice and community participation are encouraged with staff supports.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Tuesday 30 June 2020	11:10hrs to 17:30hrs	Carol Maricle	Lead
Tuesday 30 June 2020	11:10hrs to 17:30hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

During this inspection the inspectors met with all three residents, two of whom were assisted to communicate by staff.

The inspectors met with one of the residents, who communicated verbally with the inspectors. This resident told the inspectors that they were not happy living at this centre. They said that they wished to move. They repeated this on a number of occasions. They set out to the inspectors their reasons for wanting to move which included matters such as not getting along with other residents and the noise allegedly caused by other residents which in turn resulted in them having difficulty falling asleep or being woken from their sleep. This resident also gave a specific example of how they had to remain in their room during a period of escalation at the centre as it was not safe to leave. When prompted, the resident gave examples of activities they enjoyed doing and how staff supported them in this regard. The resident could identify who was in charge of the centre. The resident demonstrated a willingness to show the inspectors their bedroom and their newly created living space. They told the inspectors that they would be playing golf later that day.

The inspectors met with a second resident whose communication was interpreted by their keyworker. This resident presented as content at that time and it was clear that the keyworker understood their communication style. Through their keyworker (who acted as an advocate for the purpose of this meeting) they indicated a mixed level of satisfaction regarding living at this centre. They were reported to enjoy activities such as walks however it was reported that they were impacted by the way in which the centre was ran on a daily basis. They did not have the freedom to walk around the entirety of their home due to safety reasons when other residents were reported to be involved in escalated behaviour. Their daily planned activities were also reported to take place in reaction to what was going on in their home rather than might have actually been planned.

The inspectors met with a third resident who was supported to communicate with the inspectors by the person in charge. The resident indicated a preference to meet outside in the grounds of the centre which was respected by the inspectors. This resident preferred not to initiate conversation but did respond to questions asked with short answers and appeared comfortable when the person in charge then elaborated on their answers. This resident was asked about their experience of living at the centre and in their answers they chose instead to focus on their planned transfer from this centre to their new home. They were aware of this transfer and knew that new furniture would be arriving at their new home. Through their body language they indicated satisfaction with the planned transfer. They enjoyed showing the inspectors around the grounds of the centre and describing the purpose of the outhouses. They had an interest in art and showed the inspectors some of their art work both inside and outside the centre.

Capacity and capability

This inspection was a short-notice announced, risk based inspection carried out during the COVID-19 pandemic. This was the sixth inspection of this centre. The centre was re-registered in 2019 and a condition was applied at the time of renewal, which stated that one resident was to transfer to live in another centre. The registered provider had to adhere to certain dates when completing the agreed actions. At the time of this inspection, this action was overdue and the resident was still awaiting a transfer to their new home. The registered provider had submitted a second formal request to the chief inspector requesting additional time to be allocated for them to complete this transfer.

Overall, the inspectors found a high level of non-compliance, particularly in the area of quality and safety throughout the centre ranging from matters such as the design and layout of the centre to the rights of the residents not being upheld. The registered provider had appointed in the previous six months a person in charge and in the previous 12 months a person participating in the day to day management of the centre (PPIM) who together as a team shared a clear vision of how they wanted the centre to improve to ensure compliance with the Regulations. The staff team knew these post-holders and were clear about their roles. They confirmed that both post-holders had a good visual presence at the centre. A resident that met with inspectors also confirmed their awareness of who was in charge.

The registered provider had put systems in place to ensure governance of the centre. An annual review of the centre had been carried out in the previous 12 months, however, this review failed to demonstrate consultation with the residents and their representatives. This was of significance as two of the three residents had clear views about how they wanted to live their life and these views had not been reflected in this document. The inspectors also found that a significant review of restrictive practices had been carried out in early 2019 at the centre. None of the recommendations had been implemented and the restrictive practices committee was reported to have disbanded since that time. This was of significance as a number of the findings identified in this inspection were around the use of restrictive practices. In response to this finding, the person participating in the management of the centre confirmed that a newly formed rights committee was being established at a regional level. In the interim members of an existing rights committee that was part of the health service executive south east disability services was due to come to the centre in the weeks following this inspection to review all restrictive practices.

The statement of purpose, a document that describes the service to be provided, required significant review. The centre purported to provide a service to a group of residents reported to have needs that included challenging behaviour

that manifested itself in problematic behaviours. The centre described itself as 'secure' residential unit. The definition of what the provider meant for 'secure' was not expanded upon in the statement of purpose nor in any other accompanying documentation. This was of significance as the way in which residents were supported was based on a perceived risk that these residents may engage in high risk behaviours of a problematic manner. There was no evidence that these high risk behaviours had occurred in the preceding five years and there had been no review of the service provided in that time. This statement of purpose also set out a range of services provided, including carpentry workshop and horticulture. Neither of these services were offered at the time of the inspection, as confirmed by residents, staff and the management team.

Overall, the inspectors found that there was a dedicated staff team who strove to care for the residents. Staff spoken to and the person in charge of this designated centre advocated strongly for all the residents.There were four staff on duty on the day of the inspection. A planned and actual staff rota was in place and when viewed by an inspector it reflected staffing levels present. The skill mix of staff was observed to be sufficient to meet the needs of residents of this centre. The person in charge reported that staffing levels had been increased in recent times to mitigate against certain safeguarding risks that were present in the centre.

Procedures were in place for staff support meetings and these were scheduled to take place at least twice per year. Records viewed showed that these meetings were taking place as planned. Staff spoken to on the day of the inspection reported that they felt supported in their roles and it was evident that there were strong lines of communication between staff and the person in charge. Staff had been provided with training and staff reported that they were provided with training as required. However, training records viewed on the day were incomplete. Further information in relation to this was provided to the inspectors after the inspection. The information received indicated that a number of staff, described as new to the team, had not completed any training in fire safety procedures. Following the inspection, the person in charge had made arrangements for an online element of this training to be completed by staff.

Records relating to complaints were viewed by inspectors. There was a complaints policy and procedure in place and these had been reviewed as required. An easy read version of this was available to residents of the centre. Residents had been supported to submit complaints and this forum was used regularly by residents and by staff members on behalf of residents. Of the sample of complaints viewed by inspectors, it was clear that residents voices were listened to. Complaints were responded to quickly and some actions had been taken in response to complaints made. However, it was not clear that the complainant was always satisfied with how the complaints were resolved. In addition, some complaints were marked as resolved despite the issue pertaining to the complaint being ongoing and therefore residents did not always have an opportunity to advance their complaints to the next stage of the process as per the policy. For example, one resident had made a complaint about a delay in transferring to a new centre. The complaint has been responded to and discussed with the complainant and noted as resolved but the

issue itself was ongoing.

Registration Regulation 8 (1)

The provider had submitted an application to vary condition four that contained the required information.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge had been appointed in January 2020. She had the required experience and management qualification. She had a very good knowledge of the Regulations and standards applicable to the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that a core team of staff was in place and this matched the arrangements set out in the statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

Some staff had not completed mandatory training in fire safety.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre. The annual review of the centre did not provide for consultation with the residents and their representatives. The centre was not resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose that did not adequately set out the information in Schedule 1 of the Regulations as some of the services described were not provided. In addition, the centre was referred to as a 'secure' unit with no explanation on what this meant for the residents living there.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had given notice to the chief inspector in writing of adverse events that had occurred in the designated centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had put in place an effective complaints procedure for residents in an accessible format. Complaints were investigated in a timely manner and some measures were put in place in response to complaints. It was not clear that residents were always satisfied with the actions taken in response to complaints.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors were not satisfied with the standard and quality of care and support observed on the day of the inspection. Despite a clear management team in place and a team of staff who presented as dedicated and committed to the residents, significant improvements were required in order to bring this centre into compliance and to ensure that the rights of the residents were upheld. This inspection took place during the COVID-19 pandemic.

At the time of this inspection, there was evidence that the staff team, under the leadership of the person in charge and person participating in management, were following the guidance of the health service executive and the health protection and surveillance centre in addressing all matters relating to COVID-19. Appropriate systems were in place for protection against infection and the management of the COVID-19 pandemic. Local and individual risk assessments relating to the prevention of the COVID-19 had been carried out. On arrival to the centre, there was a designated station located inside the main door to facilitate temperature checks, screening of staff and visitors, hand hygiene and access to personal protective equipment. Staff were observed adhering to standard infection control precautions, there were adequate hand washing facilities and ample stocks of personal protective equipment available and overall there was an adequate standard of cleanliness noted throughout the centre. National standards for infection control including respiratory etiquette and hand hygiene were available in the centre. Staff were using personal protective equipment and maintaining physical distancing where appropriate in line with national guidance. Residents each occupied their own living space in the centre, with minimal contact between residents. Family contact was being maintained in line with the wishes of the residents. Staff in the centre had facilitated residents to visit family members and have visitors since the reduction in restrictions relating to the COVID-19 pandemic had taken place.

One resident had a communication plan in place that had been developed in conjunction with a speech and language therapist. This document was available in an accessible format and gave good guidance to staff working with this resident. Staff present on the day of this inspection demonstrated a good awareness of the communication needs of all residents present.There were a number of easy read documents in place relating to COVID-19, hand hygiene and cough etiquette and residents demonstrated an awareness of hand hygiene and social distancing procedures and the reasons for this on the day of the inspection.

A sample of residents' individualised personal plans were viewed on the day of the inspection. These were found to be clearly laid out and easy to navigate. Plans in place outlined the supports that residents required on an ongoing basis and provided clear guidance for staff to provide these supports. The information contained within plans correlated with information reported by staff and plans were being regularly updated and reviewed. The personal plans showed that residents were supported to access healthcare services.

The design and layout of the centre in its current form was confusing when walking around with areas such as the first floor not accessible to residents. In addition, the

main communal space, although not locked, was not accessible to two of the three residents when a third was at home. The atmosphere was institutional with staff unlocking and locking doors as they walked in and out of the centre. Residents did not always have access to recreational equipment in the garden due to certain restrictions in place. There was no clear rationale documented outlining why residents did not have free access to their expansive gardens other than potential safety concerns stated by staff.

The condition of the internal premises was poor. A communal kitchen/dining room and living space was of significant poor condition and not fit for purpose. The fitted kitchen in this space had been partially dismantled, from reported episodes of challenging behaviour leaving large gaps where fitted presses had previously been installed. This led to a very poor first impression as one walked into this communal space. Furthermore, this space was described by staff as not accessible to all residents due to the ongoing supports that a resident was reported to need. A second kitchen was available for cooking and preparation of food but there was restricted access to this room for residents. A risk assessment of the risks (if any) posed in the carpentry workshop had not been conducted.

In response to residents not having full access to the main communal areas of their home, the person in charge had, since her appointment created secondary living spaces for the residents. One of the residents enjoyed showing the inspectors their living space that they were proud of. These rooms were decorated in a personable manner and the residents appeared proud of their own space. The inspectors noted that one of these rooms contained a door into a bathroom that was locked/not in use with no clear rationale for same. Both individualised spaces were poorly laid out with mismatched furniture. Seating such as sofas were observed to be in poor condition.

The outside of the centre was significant in size and covered up to six acres of land. This land contained a horticultural poly tunnel, a carpentry workshop and an art studio located in a cabin. The poly tunnel was torn in parts and did not contain any plants/shrubs/vegetables. The carpentry workshop was described by both staff and a resident as to not be in use. An art studio was described by residents and staff as in frequent use. Some art created by residents was displayed around the exterior of the centre which was homely. The remaining land consisted of fields and the land was secured through fencing or natural ditches. There were some natural hazards such as plants and shrubbery throughout this land that required risk assessment. A health and safety assessment of the exterior buildings associated with the centre had not been conducted.

There was a significant level of restrictive practice in use in this centre not all of which had been reviewed to ensure the practice was the least restrictive available. Some practices were observed to impinge on the rights of the individuals to privacy, most notably the practice of residents requiring a 'line of sight'. This meant, that all all times, the residents (bar them spending time in their bedroom) were accompanied by staff or in their sight. The rationale for this was not set out in the documentation reviewed by inspectors. Additionally, staff were alerted to the residents leaving their bedroom at night-time as this activated an alarm. The use of

close circuit televised cameras both inside and outside of the centre were also used with no written rationale in place for same. Staff cited historical reasons of behaviours of a serious and personalised nature as the rationale for these practices. Whereas, there was evidence that some of the residents did engage in challenging behaviour that required a high level of support by staff, the need to protect residents from themselves and others from behaviours of a more personal and serious nature was not grounded in up-to-date documentation and risk assessment.

The registered provider had put in place systems designed to keep residents safe, however, a compatibility issue was impacting on the effectiveness of same. Each of the residents had a safeguarding plan and there was evidence that staff were doing what they could do to keep each resident safe and safe from each other. There had been a number of adverse incidents of aggression, both verbal and physical between two of the residents. A third resident was impacted by these incidents as the noise affected them and their daily planner was informed by escalated events that took place. Staff reported that all three residents were negatively impacted by peer to peer interactions. The safeguarding plans put in place were therefore not effective. Furthermore, the registered provider had not ensured that each resident was assisted and supported to develop knowledge, self-awareness, understanding and skills needed for self care and protection, as evidenced by key recommendations in specialist forensic reports not carried out.

During a meeting with one of the residents, they were passionate about their current dissatisfaction with living at the centre. They acknowledged that this was in part due to the ongoing incompatibility between them and another resident. However, they were committed to their view that they also wanted to leave their home and live elsewhere. The inspectors discussed this with the staff team who further elaborated on their discontent. Despite a plan put in place to address the compatibility issue at this centre, the inspectors did not find evidence of this resident having their wish to live elsewhere noted in a formal capacity, rather it was the view of staff that the resident would like to remain at this home following the transfer of another resident. The views of the resident required further exploration with them.

Regulation 10: Communication

The registered provider had ensured that residents were supported to communicate in accordance with residents' needs and wishes. Staff were aware of individual communication supports required by residents and residents had access to a telephone, television and assistive technology such as a tablet computer.

Judgment: Compliant

Regulation 11: Visits

The registered provider had facilitated each resident to receive visitors in accordance with residents wishes and was adhering to national guidance in relation to visits during the COVID-19 pandemic.

Judgment: Compliant

Regulation 17: Premises

The premises was not laid out and designed to meet the aims and objectives of the service and the needs of the residents. There was no evidence that exterior buildings were of sound construction. There was no evidence that equipment in a carpentry workshop although not in use at the time of this inspection was maintained.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

There was a plan in place to transfer a resident. The plan in itself took into account transparent criteria and the transfer was to take place in a planned and safe manner. The resident was aware of the plan and agreed with same. It was demonstrated that the timelines associated with the plan had not been achieved to date.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider did not ensure that the risk register contained reference to all of the hazards identified at this inspection

Judgment: Not compliant

Regulation 27: Protection against infection

Appropriate systems were in place for protection against infection in the centre. Appropriate personal protective equipment was available for staff and residents. National guidance was being adhered to on the day of the inspection.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that there were effective fire safety management systems in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place for residents of the centre. These were comprehensive and clearly outlined the supports required to maximise residents' personal development. Personal plans were reviewed as required and multidisciplinary input was evident throughout plans.

Judgment: Compliant

Regulation 6: Health care

The registered provider had provided for appropriate healthcare for each resident, having regard to their personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

The registered provider had not ensured that where restrictive procedures were used, such procedures were used and applied in accordance with national policy.

Judgment: Not compliant

Regulation 8: Protection

The person in charge had initiated and put in place investigations in relation to incidents, allegations or suspicion of abuse. The registered provider had not ensured that each resident was assisted and supported to develop knowledge, self-awareness, understanding and skills needed for self care and protection, as evidenced by key recommendations in specialist reports not being cross referenced in personal planning arrangements.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not ensure that residents had the right to exercise choice and control in their daily lives.

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
Capacity and capability	
Registration Regulation 8 (1)	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Leeside OSV-0003319

Inspection ID: MON-0029602

Date of inspection: 30/06/2020

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 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 has now received fire training. The PIC will continuously review the training matrix to ensure that all staff has mandatory training and development.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The revised Governance and management plan will ensure a more robust and efficient lines of management. The statement of purpose will be reviewed to reflect the current service delivery. The annual review for the centre will be completed in consultation with residents and their representatives	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The PIC and PPIM has reviewed the statement of purpose to reflect the current service delivery.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The complaints process has been reviewed in line with service policy. The PIC will provide complaints training to all staff by the 25/09/2020.	

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A review of all restrictions took place on the 8th of July, a number of restrictions were removed. It is expected when 1 resident relocates the house will be laid out and designed to meet the aims and objectives of the service and needs of the resident. A list of priority works have been devised in line with the maintenance manager, it is expected that works will commence on the 17th of August 2020. A Budget has been approved to complete these works. Furniture and household equipment has been ordered and progressed for purchasing. The PIC has requested the Health and Safety advisor to conduct an assessment on exterior buildings. The carpentry workshop has not been accessible to residents since 2018. Carpentry equipment will be removed.	
Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents: The resident will be relocating on the 7th of September 2020 to an apt in another centre.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Health and safety advisor will support PIC to identify hazards and control measures in relation to the external buildings. The PIC and service psychologist will review all psychological risk pertaining to the risk management policy on the 19th of August 2020. Service psychologist will recommence undertaking Psychological assessments for residents in consultation with the staff team and the PIC has been advised that it is best to do so once another resident has relocated.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A rights committee was held on the 08th of July 2020, a full review of all restrictions in the designated centre occurred in line with national policy. CCTV was removed from the centre. A number of restrictive procedures remain in place until the resident relocates, to ensure the safety of all residents.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection:	

An identified training in the good live model will be delivered by the Service Psychologist to all staff once the resident relocates. 21st Sept 2020.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: A reduction in the restrictions within the house has been reduced following a rights committee review on the 08/07/2020. The annual review will be conducted in consultation with the residents. Key workers will liaise with each resident to discuss formally their wishes and rights. A component of the Good Live Model training will ensure that staff are competent to support each resident in this area.	

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 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	14/08/2020
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	07/09/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Not Compliant	Orange	12/09/2020

	state of repair externally and internally.			
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Orange	25/08/2020
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	13/08/2020
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'	Not Compliant	Orange	30/09/2020

	needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	30/09/2020
Regulation 25(4)(c)	The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed in accordance with Regulation 5(1) and the resident's personal plans.	Not Compliant	Orange	07/09/2020
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	19/08/2020
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the	Not Compliant	Orange	19/08/2020

	measures and actions in place to control the risks identified.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	14/08/2020
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 the resident was satisfied.	Substantially Compliant	Yellow	25/09/2020
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	30/09/2020
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Substantially Compliant	Yellow	30/09/2020

	this Regulation all alternative measures are considered before a restrictive procedure is used.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	31/10/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	07/09/2020
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	31/10/2020
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to	Not Compliant	Orange	07/09/2020

	exercise choice and control in his or her daily life.			