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:	Suaimhneas Respite
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	22 November and 28 November 2022
Centre ID:	OSV-0005760
Fieldwork ID:	MON-0038435

About the designated centre

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

Suaimhneas Respite is a designated respite centre created to support men and women with an intellectual disability that require low to medium support. The support provided varies depending on the residents' needs and requirements. They will range from basic care needs i.e. health and personal care, building and maintaining basic daily living skills to social supports such as social skills development, support in organising and accessing social activities, developing and maintaining relationships and community links. The designated centre is located in a town in County Wicklow with a maximum capacity of four residents at any one time. The centre is managed by a person in charge who has a remit for two designated centres. They are supported in their role by a deputy manager. The person in charge reports to a senior services manager. The whole-time-equivalent staffing ratio for the centre is 5.9 as set out in the provider's statement of purpose.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 22 November 2022	12:00hrs to 19:30hrs	Louise Renwick	Lead
Monday 28 November 2022	11:50hrs to 19:30hrs	Louise Renwick	Lead
Monday 28 November 2022	11:50hrs to 19:30hrs	Ann-Marie O'Neill	Support

What residents told us and what inspectors observed

This unannounced inspection took place over two days and was in response to solicited and unsolicited information received by the Chief Inspector.

Notifications received by the Chief Inspector, outlined two serious incidents that had occurred in the designated centre in October 2022 and a noted increase in the frequency of self-injurious behaviour incidents notified on quarterly reports for the designated centre. Unsolicited information received also raised concerns about the provider's ability to appropriately mitigate, respond to and manage such incidents and as a result inspectors carried out a focused risk inspection of this designated centre over two separate days.

The first day of inspection reviewed the centre when it was operating under its usual respite service arrangements for residents with low to medium support needs that attended occasionally for short stays. The second day of inspection reviewed the centre when it was providing a more intensive and regular service for residents with higher support needs and risks associated with behaviour of concern.

The first day of the inspection was unannounced, the inspector met respite users who were attending for respite breaks together on the day. The second day of the inspection was also unannounced, and took place six days later when other respite users with higher support needs were in the designated centre. Inspectors had the opportunity to meet them and observe their day to day life in the centre. Inspectors also met some staff working in the centre across the two days, the person in charge, and later on the second day the senior manager, quality manager and the Chief Executive Officer.

On the first day of the inspection, an inspector met respite users who were visiting or staying overnight for a short respite break. Residents were seated together in the main living room watching a movie on the television and chatting with each other. Residents appeared relaxed and there was a nice atmosphere with residents joking with each other and watching funny videos on their phones.

They told the inspector they liked to visit the centre, that it was nice and some residents already knew each other from day services or other services. Some residents had chosen to visit the centre for the evening meal, but would return home later in the evening, this was to support them to get used to the designated centre and to choose to stay over-night when it was familiar and comfortable to them.

On the second day of inspection in the afternoon and evening, inspectors spent time with residents. One resident was relaxing on the couch watching their favourite movie with one staff member present. The other resident had chosen to spend time in their bedroom.

While moving about the premises, inspectors observed that it required upkeep and repair due to damage in a number of locations. Inspectors saw large dents and cracks in the walls in various areas of the centre, including some resident bedrooms. These had been caused by incidents of self-injurious behaviour in the previous months. While requests had been made to the provider to have these repaired, the provider had not taken steps yet to address them. The person in charge and local team had attempted to cover some of these by hanging canvas art and pictures over them, until they were repaired.

The designated centre had one main communal space available for residents, which was a sitting room with a dining room table, and an open plan kitchen with a kitchen island that had recently been altered to offer staff a second pathway to leave the kitchen space should an incident of behaviours that challenge occur. This living room/kitchen area had one exit door, which entered into a small hall and corridor. There was one staff office/ sleep over room off the hall, and the remaining bedrooms were respite resident bedrooms.

Due to the respite nature of the designated centre, bedrooms were decorated in a plain manner, and each had a sink, a bed, a wardrobe and television. One television had been damaged, and therefore removed by staff due to presenting risk. However, the frame and wiring remained in place. Due to property damage in certain bedrooms, residents had been offered different rooms during their stay. However, this had resulted in further damage.

Overall, this inspection found that for some weeks in the month, the registered provider was operating the designated centre in line with their written statement of purpose and providing respite care and support to up to four people with low to medium support needs. For these weeks, residents appeared happy with their centre and service, had a pleasant experience and enjoyed coming into respite.

However, on alternate weeks when the provider admitted residents with higher support needs and more intensive therapeutic support requirements, the provider was failing to manage risk and deliver a safe good quality service to residents that was meeting their complex support needs. Inspectors identified significant non-compliances that were impacting on the safety and quality of life of residents during these weeks. These included issues with staffing, oversight and management, positive behaviour support and risk management. The provider did not demonstrate that they could safely meet the needs of residents on these weeks and had failed to take effective action to address the ongoing risks in the centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

On the weeks that the provider was providing respite services in line with its Statement of Purpose, inspectors found that the provider was delivering a good quality service which residents confirmed that they enjoyed.

However, on the alternate weeks, the provider and person in charge did not demonstrate they had the capacity, capability or resources to operate this designated centre in a manner that kept residents safe at all times and offered them a good quality service. Inspectors found that the registered provider had not put suitable arrangements in place for the mitigation, control or response to risks presenting in the centre on those weeks.

Inspectors found poor oversight arrangements in the centre and that the provider did not put adequate resources in place to support staff to respond to the complex needs of residents.

The provider's auditing was ineffective in that it did not identify significant risk issues. There was poor recording of incidents in the centre and consequently the provider could not learn from them and take measures to manage that risk. There was a heavy reliance on agency staff, many of whom were unfamiliar with the complex needs of residents, there was poor staff training and the provider was not ensuring that staff had the knowledge and competency to respond to the needs of residents.

Inspectors also found that the provider had not put adequate support arrangements in place for staff when significant incidents occurred in the centre. Inspectors saw where an incident of significant concern had arisen in previous months and the staff had been unable to contact any manager for support. Following this, the provider failed to put adequate on-call arrangements in place and staff were expected to manage such incidents and at the same time to ring around other centres in the area to see if they could make contact with a manager or other staff for support.

Regulation 15: Staffing

Under this regulation the provider was required to address an immediate risk that was identified on the second day of the inspection. The manner in which the provider responded to the risk did provide assurances that the risk was adequately addressed.

The immediate action was in relation to ensuring that there was an identified staff on duty at all times this week who was adequately trained in medicine administration (including the administration of PRN (as required)) and emergency first aid.

The provider responded with verbal assurances that one staff out of three on duty were rostered on duty each day and evening for the week of 28 November who were trained in emergency first aid and the safe administration of medicine. The

provider was awaiting on further information from an external body to confirm that temporary agency staffing appointed to work in this centre this week, had been trained in these two areas. However, written confirmation or records of this was not available at the time of inspection.

The provider also provided the inspectors with a written protocol outlining that if there was not three staff available to work in the designated centre, then they would inform respite residents that they could not attend for safety reasons. This was observed to be followed through on inspection.

Overall, the provider was heavily reliant on the use of temporary agency staffing, provided by an external agency to operate their service. This resulted in inconsistent approaches to supports for residents, and did not support a predictable staff team which some residents required. While the provider had risk controls in place, to ensure a minimum number of staff were available to work in the centre with residents, they did not have measures to ensure there must always be one familiar and permanent staff, known to residents available at all times.

Staff rosters were not fully managed in a way that alleviated potential disruption or risk. For example, not rostering new agency staff to come into the centre earlier to ensure a comprehensive induction, prior to meeting residents. Or requesting residents attend for respite prior to a full staff team being on duty and present in the centre.

The provider was not ensuring an adequate skill mix of staff, that was aligned to residents' needs was in place at all times.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider was not adequately resourced to operate this designated centre in a manner that was resulting in a good quality service. For example, the reliance on temporary agency staffing, the inadequate premises and environment to meet the specific needs of residents.

The provider's management systems had failed to identify and review areas in need of improvement, or to put a plan in place to adequately address them. For example, while risk increased over a period of months, this did not trigger the provider to complete an additional audit or comprehensive review.

The management systems in place were not utilising information gathered about the centre to ensure it was safe and fully meeting the needs of all residents. For example, following two serious incidents, a provider assurance report request from the Chief Inspector and patterns of increasing risk since the summer, it was seen that some changes to manage risk had only been implemented following staff formally raising concerns. Similarly, the provider had failed to adequately respond to

urgent compliance plan requests following day one of the inspection, and immediate action responses during day two of the inspection.

While the provider was aware of the high level of risk in their designated centre, this was not based on evidenced based gathering and effective use of information. The recording and reporting systems in the designated centre were not robust, and allied health professionals did not have clear information to assist them in altering supports for residents, as needed.

Improvements were also required to the management structure and operational management of the designated centre, for example the person in charge was responsible for two designated centres and had to provide intensive support in this location to the staff team. Similarly, their time was consumed with managing staffing rosters and agency shifts and providing telephone communication to families.

Where staff had raised concerns through the formal complaint process, or through formal meetings with the provider regarding residents' safety, inspectors were not assured that information was being used to bring about improvements.

Judgment: Not compliant

Regulation 3: Statement of purpose

The written statement of purpose and function was not a true reflection of what was being provided for in the designated centre.

The registered provider was supporting residents with more complex support needs than was outlined in their written statement of purpose, and did not outline in the written document the therapeutic interventions required or the specific staff training that all staff would require in order to support such needs.

The registered provider had amended the layout of the premises, by moving a staff office/ sleep over room to an area outside of the footprint of the designated centre.

Judgment: Not compliant

Quality and safety

The designated centre was not resourced, operated or managed in a way that resulted in safe, good quality care and support to residents using the service on alternative weeks.

The provider and local management team did not have suitable arrangements, oversight mechanisms, resources or strategies in place to respond to and reduce the liklihood of harm to all residents and ensure they were receiving a good quality service.

The provider did not ensure that at all times in the designated centre, suitable safeguarding arrangements were in place to keep residents safe from harm, most notably at night-time.

While safeguarding plans were in place for residents who were known to be at risk of potential physical harm during the day-time, the provider had not taken measures to ensure residents' wellbeing was safeguarded and that they felt safe and at ease while staying in the designated centre, even when information indicated this was not the case.

For example, some residents spent long periods of time in their own room, choosing to lock their door and at times eating all meals in their bedroom when staying in respite with peers. In October 2022 staff raised a complaint on behalf of some residents regarding the impact of incidents on their well-being, but this complaint was closed off as it was deemed to be already monitored through the safeguarding process. At a meeting later in October 2022, staff raised concerns again regarding the safeguarding issues and the compatibility of some peers together.

Due to the resources and management of the designated centre the provider and person in charge had not ensured that residents were supported with a consistent approach to their care and support in the designated centre that was meeting their needs. For example, the behaviour support plan outlined the requirement to maintain visual observation during certain behaviours, however on review of recorded incidents there were times when staff could not provide this due to the layout of the premises and the location of incidents.

Residents were not protected by effective risk management or incident reporting systems in the designated centre.

The provider and person in charge had failed to ensure information was being recorded and captured effectively through the provider's records and incident recording systems. For example, staff spoke of a near miss incident that had occurred in the designated centre in previous weeks that had not been recorded. Therefore, allied health and social care professionals were not getting clear information to better inform their interventions or responses and to inform support planning arrangements or risk-based measures for residents.

The resources and staff skill-mix available, inconsistent application of supports and risk control measures along with the design of the premises were impacting on the staff team's ability to meet residents' needs, and to keep them safe at all times. The oversight and monitoring of the day to day delivery of the care and support in the designated centre was ineffective at promoting a safe, and good quality service to residents during certain weeks.

Regulation 26: Risk management procedures

Under this regulation the provider was required to address an urgent risk that was identified on the first day on the inspection. The manner in which the provider responded to the risk did not provide assurance that the risk was adequately addressed. The provider failed to submit adequate written assurances by the timeline given, and once received the written response was inadequate. The risks identified following the first day of the inspection were that the registered provider was failing to keep all residents safe, and were not ensuring adequate and effective measures were in place to protect residents from injury. Also, the provider did not have adequate systems in place to respond to emergency situations that could result in injuries to residents, staff and visitors.

Under this regulation the provider was required to address an immediate risk that was identified on the second day on the inspection. The manner in which the provider responded to the risk did not provide assurance that the risk was adequately addressed.

The provider was issued an immediate action during the second day of inspection, to ensure there was a clearly defined and detailed on-call emergency support available for staff to contact in the event of an injury or emergency, which would provide managerial support and leadership verbally over the phone, or in person in the centre, if required.

The provider gave inspectors a written protocol detailing and naming which senior manager the staff team could contact on different days of the week of 28 November 2022. However, when inspectors returned to the designated centre later that evening the person in charge and staff team had not been informed of this protocol or given any information regarding the changes made. Inspectors could not leave the designated centre, until the provider had been instructed to send written confirmation of the improved protocol to the person in charge and staff team in the designated centre.

Overall the registered provider was failing to keep residents, staff and visitors safe from identified risks. For example, there was an absence of a clear monitoring plan to visually support and monitor residents who may harm themselves.

Incident management system was inadequately used to inform the provider and members of the multidisciplinary team of emerging incidents and/ or behaviour that may impact on risk assessments, or supports in place for residents.

The provider and person in charge had not considered, or assessed some potential risks regarding this designated centre, based on the information in the recording system. For example, the risk of visitors or allied health professionals coming to the designated centre, or the risk of families not being in a position to collect respite users following their stay.

The control measures in place to manage some risks, had not been considered in relation to their impact on the quality of life for residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was an absence of comprehensive assessments of residents' needs while in this designated centre, in relation to the environment, premises and compatibility between peers. While there was input from allied health and social care professionals in the creation of personal plans, there were barriers to interventions or further assessments being completed due to the escalation of risk.

Information in personal plans to support positive behaviour was comprehensive, however there were conflicting guidance documents for staff to follow in the event of certain incidents. For example, when to use a physical restraint. Guidance within certain plans could not be fully followed due to the lay out of the premises, or due to some aspects not being fully in place yet.

There was no written plans or guidance for staff to consistently follow, should residents engage in self-injurious behaviour from a health-care perspective. For example, how residents would be checked or reviewed to determine if an injury had occurred, and how to record the presence of injury.

The designated centre was not suitable for the purpose of meeting all residents' needs. The provider had not adapted the premises to safeguard residents from potential harm.

Judgment: Not compliant

Regulation 8: Protection

Under this regulation the provider was required to address an urgent risk that was identified on the first day of the inspection. The manner in which the provider responded to the risk did not provide assurances that the risk was adequately addressed. While inspectors found that the provider and person in charge was protecting some residents from physical harm, they had not determined the impact of incidents on residents well-being and emotional health, where residents were indicating signs of distress and signs of feeling unsafe.

Under this regulation the provider was required to address an immediate risk that was identified on the second day of the inspection. The manner in which the provider responded to the risk did not provide assurance that the risk was

adequately addressed.

While safeguarding plans were in place to protect residents from harm from their peers during the day-time, with three staff available to support and supervise residents, there were inadequate arrangements for during the night-time.

At night, three staff worked sleep-over shifts in the designated centre. There was evidence that residents could wake up during the night, to leave their room or use the shared bathroom. There were inadequate arrangements in place to support residents during the night-time and keep them safe.

The provider responded with a plan to install two bed sensor alarms for residents the next day 29 November 2022, this would alert sleep over staff that residents were awake and had left their beds. However, no additional measures were put in place to safeguard residents on the evening of the inspection.

Not all incidents of potential indicators of harm were being appropriately screened and reported to determine if there were grounds for concern, or additional safeguarding measures were required.

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 (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	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Suaimhneas Respite OSV-0005760

Inspection ID: MON-0038435

Date of inspection: 22/11/2022 and 28/11/2022

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: Confirmation via email of required mandatory training completed by agency staff in relation to Emergency First aid and Safe administration of Medication will be requested as part of the booking process beginning January 2023.

In addition to this agency staff will be requested to begin their shift 30 minutes prior to direct support to provide more protected time towards induction and handover. The earlier start time will have the added benefit to alert the provider should non attendance of agency staff occur. This earlier start time for agency staff allows the designated center sufficient time with adequate staffing present to support the respite users whilst sourcing an additional staff.

The name and contact numbers of agency staff due to start a shift will be requested by the provider, and these staff can be contacted should any issues such as non attendance or lateness arise to ascertain if the agency staff will be attending the allocated shift.

Every effort is being made by the provider to recruit staff to provide consistency and continuity of care to support the respite users

An interview for a Permanent post was conducted week of 12.12.22 and the candidate was successful, SHS are awaiting confirmation of their acceptance of role.

The Provider implemented the below strategies in relation to the recruitment of staff.
• Regarding recruitment, the Provider ran an open day on the 8th of November 2022. SHS will be planning another such event in the New Year .

• SHS ran recruitment advertisements on local radio and multimedia formats in November 2022.

• SHS are exploring running 2 Open Days overseas in 2023.

• The human resource department will be attending some college Open Days in 2023 when college schedules are confirmed.

There is a local protocol agreed should sufficient staff not attend their shift at short notice and no adequate staffing cover be sourced. Family and staff are aware of the process in this eventuality.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There have been ongoing discussions between the HSE and external service providers to provide a new residential service that meets the identified needs of the individuals, with the appropriate skill mix of staff. A service provider has been identified by HSE and commencement date of the service will be submitted to HIQA as and when received from the HSE.

In line with the HSE Incident Management Framework a concise review of the incident will be conducted using the system analysis methodology within the time frame allowed by the IMF.

A 6 monthly provider audit will be conducted for Suaimhneas on the 4th of January 2023.

An instruction and guidance document has been sent to all PICs to give agency staff access to the central information database to record all incidents. These incidents are reviewed by the PIC and PPIM as part of the internal incident management system

If for any reason a staff member is unable to record an incident, this must be communicated to the PIC or their Deputy and they will ensure the incident is logged in a timely manner. In the event the CID system for logging incidents is unavailable there are manual reporting sheets that can be completed by agency or regular staff. These will be scanned and saved to the clients documentation section on the internal electronic system the following day to ensure incidents are captured and responded to accordingly.

The provider is actively recruiting for a Deputy client services manager who will support the overall governance and management of the designated centre. As an interim measure a nominated person is supporting the designated centre with the booking and confirmation of agency staff, therefore allowing the local management improved oversight and management of the designated center.

The provider is meeting regularly with HR and staff to address local issues

The behavioral specialist provides ongoing support and guidance in relation to the implementation of the positive behavioral support plan to ensure that staff have the ongoing practical knowledge to implement the recommendations. The most recent support session occurred on the 16.12.22 and will continue on an ongoing basis. Following any serious incidents, the behavioral specialist will be informed to provide learning and guidance.

In relation to patterns of increasing risk the provider will ensure the nominated person with responsibility for conducting 6 monthly Provider and Annual audits and Health & Safety officers yearly audits will run incident reports from the organisation's CID database to identify incidents where there is evidence of an increase of self-injurious behaviours, damage to property or any serious incident prior to visiting the designated centre. The control measures will be reviewed by the auditor as part of the review to check the adequacy of control measures. Where there is evidence that control measures in place are failing to mitigate the risk this will be immediately communicated to the PIC, PPIM and QCT Manager. Where adequate resources are not available, the Provider Nominee will be informed who in turn will inform the Board.

Where immediate actions are required to be implemented, the PPIM or Quality, Compliance and Training Manager will ensure these actions are communicated to the PIC and staff team of the particular designated centre in a timely manner.

In relation to staff raising concerns via the formal complaints process, the provider has engaged with staff and their representatives on an ongoing basis to review and implement viable improvements, in conjunction with the providers' human resource department and other external representative groups.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The provider will review the current statement of purposed and function by 15.2.22, this will provide a more accurate reflection on what services and supports can be provided in the designated centre, including therapeutic interventions and specific staff training required to support such needs.

The services for the individual are currently being reviewed, and in line with this a temporary measure was implemented to provide additional staffing to support the resident and staff in a safer manner. New floor plans will be submitted to include this area as part of the updated Statement of purpose and function by 15.2.22.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Going forward the Provider will submit written assurances by the requested timeline given and every effort will be made by the provider to ensure the responses are robust and effective.

Where immediate actions are required to be implemented, the PPIM or Quality, Compliance and Training Manager will ensure these actions are communicated to the PIC and staff team of the particular designated centre in a timely manner.

There is a qualified first aid trained staff on shift rostered, staff are reminded to follow their first aid training, should an incident occur that is outside of their training, staff should seek immediate medical assistance.

In order to provder a greater level of monitoring residents who may harm themselves at night the provider has installed an alarm in the residents bedroom to alert staff should a client wake during the night to allow staff to support and monitor residents.
The behavioral specialist provides ongoing support and guidance in relation to the implementation of the positive behavioral support plan to ensure that staff have the ongoing practical knowledge to implement the recommendations, this occurred as recently as 16.12.22 and will continue on an ongoing basis, and following any serious incidents the behavioral specialist will be informed to provide learning and guidance.

In relation to patterns of increasing risk the provider will ensure the nominated person with responsibility for conducting 6 monthly Provider and Annual audits and Health & Safety officers yearly audits will run incident reports from the organisation's CID database to identify incidents where there is evidence of an increase of self-injurious behaviours, damage to property or any serious incident prior to visiting the designated centre. The control measures will be reviewed by the auditor as part of the review to check the adequacy of control measures. Where there is evidence that control measures in place are failing to mitigate the risk this will be immediately communicated to the PIC, PPIM and QCT Manager. Where adequate resources are not available, the Provider Nominee will be informed who in turn will inform the Board.

Options to provide alternative respite dates to another resident have been communicated to the resident's family member on the week of 12.12.22. At this time the family did not wish to pursue this option, however the provider assured the family this could be revisited should they wish. This measure was proposed as a potential mitigation of the risk in relation to negative impact / poor quality of life experiences whilst receiving respite.

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 review of guidance documents and support plans will be reivewed to ensure there are robust and effective. This will be completed by 28.2.2023
The positive behavioural support specialist will and local management will continue to work together to continue to update plans and communicate same to staff in the designated center.
There is a qualified first aid trained staff on shift rostered, staff are reminded to follow their first aid training, should an incident occur that is outside of their training, staff should seek immediate medical assistance.

The presence of any injuries to a resident will be recorded via the internal incident reporting system.

The behavioral specialist will be requested to review the positive behavioral support plan should residents engage in self injurious behavior to provide guidance to staff in how to support a resident during an incident of self injurious behavior and also assessing how a resident would be checked to assess if an injury had occurred.

The residents' bedroom will be modified to provide more protective surfaces. These materials have been sourced and an external contractor is expected to have them installed by end of January 2023.

The maintenance department has confirmed that the upkeep of the plasterboard and painting will commence this week 19.12.22 and will be completed prior to re-opening of the designated center in 2023.

There are ongoing discussions between the HSE and external service providers to provide a new residential service that meets the identified needs of the individuals, with the appropriate skill mix of staff. The outcome of these discussions will be submitted to HIQA as and when received from the HSE.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
While inspectors found that the provider and person in charge was protecting some residents from physical harm, they had not determined the impact of incidents on residents well-being and emotional health, where residents were indicating signs of distress and signs of feeling unsafe.

Going forward the Provider will submit written assurances by the requested timeline given and every effort will be made by the provider to ensure the responses are robust and effective.

Where immediate actions are required to be implemented, the PPIM or Quality, Compliance and Training Manager will ensure these actions are communicated to the PIC and staff team of the particular designated centre in a timely manner.

In relation to the impact of incidents on other residents well-being and emotional health, options to provide alternative respite dates to another resident have been communication to the resident's family on the week of 12.12.22. At this time the family did not wish to pursue this option, however the provider assured the family this could be revisited should they wish. This measure was proposed as a potential mitigation of the risk in relation to negative impact / poor quality of life experiences whilst receiving respite.
A internal social work referral has been submitted on the 20th December 2022 as the respite service is closed for Christmas period and this resident does not return to service until 9th January 2023. This referral is to allow SHS social work team to assess if further risk mitigation measures are required to promote the health and wellbeing of the other resident.
In order to provide a greater level of monitoring residents who may harm themselves at night the provider has installed an alarm in the residents bedroom to alert staff should a client wake during the night to allow staff to support and monitor the residents' activities.
An instruction and guidance document has been sent to all PICs to give agency staff access to the central information database to record all incidents. These incidents are reviewed by the PIC and PPIM as part of the internal incident management system

If for any reason a staff member is unable to record an incident, this must be communicated to the PIC or Deputy and they will ensure the incident is logged in a timely manner. In the event the CID system for logging incidents is unavailable there are manual reporting sheets that can be completed by agency or regular staff. These can be scanned and saved to the clients documentation section on the internal electronic system, the following day to ensure incidents are captured and responded to accordingly.

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	Red	31/03/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/03/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	31/03/2023

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	28/02/2023
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	28/02/2023
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	28/02/2023

Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Not Compliant	Red	28/02/2023
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	28/02/2023
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	Not Compliant	Orange	28/02/2023

	resident's quality of life have been considered.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Red	28/02/2023
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	15/02/2023
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	28/02/2023
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are	Not Compliant	Orange	28/02/2023

	in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/02/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/02/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	28/02/2023
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	31/03/2023