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:	Hazel Grove
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	21 March 2023
Centre ID:	OSV-0004638
Fieldwork ID:	MON-0033881

About the designated centre

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

Hazel Grove comprises of two properties located within a relatively short drive of each other. Both properties are located in populated areas in walking distance of services such as shops, restaurants and public transport links. The centre provides a residential service for a maximum of six residents assessed as requiring a broad range of staff support. The support provided ranges from supervision to full support with all activities of daily living. One property is a single-storey detached house where an individualised service for one resident is currently provided. The other property comprises of four apartments that accommodate residents on a single occupancy or shared basis; the maximum possible occupancy of each apartment is two residents. The apartments offer semi-independent living arrangements for residents. In each location there are two staff available to offer care and support during day-time hours and one staff during night-time hours. The model of care is social and the staff team is comprised of social care and support workers with day-to-day management delegated to the person in charge supported by a lead social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 21 March 2023	09:45hrs to 18:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to monitor the provider's level of compliance with the regulations and standards. The inspection findings were not satisfactory. There was evidence that residents themselves were happy with their quality of life and the provider was responsive to resident's needs and risks. However, overall the provider did not adequately demonstrate that it had all of the controls and arrangements in place to consistently ensure and assure the appropriateness, quality and safety of the service.

For example, the designated centre is comprised of two separate units. On arrival at the first unit which consists of 4 apartments, the well-being of the inspector was established prior to entering any apartment so as to reduce the risk of inadvertently introducing infection to the service. However, sometime after this it became apparent to the inspector that the provider's own outbreak response plan which should have been implemented in one apartment had not been implemented. This resulted in a change to the planned process of inspection. The inspector did not re-enter the apartments that had been visited and did not visit the second unit so as to reduce the risk of the spread of infection. The provider's outbreak plan was implemented by the person in charge who came on site to support this unannounced inspection.

These inspection findings therefore in the main pertain to one unit but the inspector did request and review records from the other unit.

Prior to the infection prevention and control risk arising the inspector had the opportunity to visit three of the four apartments and to meet and speak with four of the five residents living in the apartments. One resident had left the centre for the day to attend an off-site education and training programme. Each of the four residents met with welcomed the inspector into their apartments; two residents shared an apartment. Residents chatted easily about life in general and their daily routines in the centre. It was evident that the residents took pride in their personal appearance and their apartments. Residents showed the inspector improvements that had been completed such as the refurbishment of kitchen units and spoke of further plans that they had such as getting additional shelving or new tables and chairs. Residents spoke of how they had spent the recent public holiday such as enjoying lunch out supported by staff and their celebration of recent birthdays. There was a great display of celebratory balloons, cards and flowers in one apartment.

One resident had an interest in the work of the inspector and spoke of the time they had spent in different services and peers that they had lived with in other settings. The resident told the inspector that they loved living in their apartment and that life was "grand". Likewise, another resident spoke of how they loved living on their own and liked the independence that they had. This resident had a visual white board

that listed their planned activities for the week such as swimming, participating in the tidy towns, volunteering and attending mass. The resident confirmed that they attended all of these and also enjoyed activities such as going for a hot-shave. The resident did however express some anxiety over the continuity of the staffing arrangement that supported these activities with them.

Two residents spoke of how they accessed and enjoyed off-site community based day services on a regular basis. A resident spoke of their enjoyment of art and crafts programmes that they attended. Residents had contact with home and family and could receive visitors in their apartments as they wished. The inspector did not meet with any resident representative but saw feedback that they had recently provided to inform the providers annual review of the service. The feedback was positive.

Residents had also provided feedback to inform the annual review. Some residents were supported by staff members to provide their feedback. Resident feedback was detailed and informed and echoed much of what residents told the inspector and what the inspector observed. For example, the varied routines and community access that residents enjoyed and, the choice and control that they had in their apartments and in their daily routines. Residents said that they could choose their own goals and objectives, could choose their own meals and receive visitors as they wished. However, residents had also raised some matters that they were not so happy about such as the staffing arrangements of the apartments or how safe they felt sometimes at night. Two residents had reported that they liked living in the centre most of the time but not always.

The inspector reviewed records and discussed with the management of this service this feedback and other areas such as risk management, staffing levels and arrangements, staff training, fire safety and behaviour support. The inspector found that each resident had support needs, some of these needs were complex and had associated risks and, residents' had differing and at times competing needs. This meant that the operation and management of the service still encompassed supporting residents to live semi-independently and to take positive risks, the provider also had to manage and respond to risks that were at times significant in terms of the risk that they posed to resident safety and wellbeing. These inspection findings did not provide the necessary assurance that the provider had the arrangements in place in response to these needs and risks. For example, the provider itself had an open high red rated escalated risk in relation to the current staffing levels and arrangements. A business case had been submitted to its funding body.

In summary, while it was evident that on many levels residents were enjoying a good quality of life much improvement was needed for the provider to evidence it had the arrangements in place to assure the appropriateness and consistent safety and quality of the service provided to residents.

The next two sections of this report will discuss the governance and management arrangements of the service and how these impacted on the quality and safety of the service.

Capacity and capability

The provider did not demonstrate the good level of compliance with the regulations evidenced on previous inspections of this centre. The provider itself had identified that the service was not adequately resourced to ensure the delivery of a safe and appropriate service for residents.

The current person in charge was relatively recently appointed and was familiarising themselves with the residents and the staff team. The person in charge was supported by a lead social care worker who had allocated administration time. The person in charge had ready access to their line manager. The person in charge was present in the centre at a minimum three times each week. However, a staffing risk assessment and business case that will be discussed further below, also included a requirement for additional administration resources to ensure the effective administration and oversight of the service.

It was evident that the person in charge in collaboration with their line manager was implementing systems of oversight such as a schedule of staff supervisions, comprehensive reviews of accidents and incidents and regular staff meetings. However, there were concerning findings such as the requirement of the person in charge to issue ultimatums to members of the staff team to complete mandatory and required training. This was training that was needed in response to assessed needs and risks to ensure that residents were provided with a safe quality service.

It was evident from these inspection findings that while the provider had established systems and processes in place to underpin the safe delivery and oversight of the service, deficits had arisen in the application of these systems. Systems of oversight had not always identified when and where corrective actions were needed. For example, the oversight of simulated evacuation drills.

Residents did receive continuity of care and support from a regular team of staff. Nursing care if needed was accessed from community based and specialist resources such as the local palliative care team. However, there was evidence to support that the current staffing levels and arrangements were not always appropriate to the number and needs of the residents or, the design and layout of the service.

Regulation 15: Staffing

There were times during the week when the occupancy of the service was reduced by day as residents attended off-site services and programmes. Residents did enjoy good independence on many levels but there were needs and risks that needed to be monitored, managed and responded to and, each of the five residents had some

requirement for staff support, some more than others. However, there was a maximum of two staff members on duty from 09:30hrs to 20:30hrs. There was evidence that these staffing levels were not at all times appropriate to the assessed needs and associated risks of the residents or the design and layout of the apartments. For example, there was a reliance on community employment schemes to provide individualised supports and one resident spoken with expressed anxiety in relation to the continuity of this arrangement. There was one staff member on sleepover duty at night but that staff member was not based in the apartment where two residents with higher needs and risks resided. One of these residents had stated in their feedback that there were times at night when they did not feel safe when they could hear people and cars outside the apartment. Feedback provided by a member of the staff team on a residents behalf described how a resident's routines and choices could be compromised by the needs of their peer. The peer required staff supervision for all meals and the person in charge said that this could impact on the timeliness of the support needed by the other resident for their personal care. A staff member had recently recorded that they had limited time to spend with another resident due to the support needs of a peer who would have been assessed as having a low need for staff support. The provider itself had, in November 2022 created a high red rated risk for the adequacy of its staffing levels and arrangements to ensure a good quality safe service for all five residents. A staffing deficit of 61.5 hours weekly had been identified by the provider.

Judgment: Not compliant

Regulation 16: Training and staff development

Based on the inspectors review of the staff training matrix deficits in staff attendance at baseline and refresher training were being addressed. However, staff training requirements were still not fully complete such as practical training in interventions for responding to behaviour that challenged and medicines management training.

Judgment: Substantially compliant

Regulation 23: Governance and management

Based on these inspection findings the provider did not adequately demonstrate how the governance and management systems in place ensured that the service provided was safe, appropriate to residents needs individually and collectively, consistently and effectively monitored. There was evidence that more robust application of the providers quality assurance systems was in progress but also evidence that deficits had arisen in these systems and, robust measures had been needed to address shortcomings. For example, records seen indicated that

extraordinary measures were required of the person in charge to ensure that staff members completed training required of them. Inadequate oversight had been maintained of areas such as the providers evacuation procedures and accidents and incidents that had occurred. The person in charge confirmed that they had since their appointment re-analysed incidents that had occurred and was also in the process of analysing the simulated drills that had been completed to date. There was evidence of corrective actions taken and planned such as referral to members of the Multi-Disciplinary Team (MDT) and, further education for residents in areas such as fire safety. However, management, systems of review and the implementation of corrective actions were fragmented and did not robustly and effectively bring about the improvement needed to assure the quality and safety of the service. For example, while there was evidence of MDT input, there was no risk assessment, current positive behaviour support plan or protection plan put in place in response to incidents that had occurred.

The provider needed to ensure that the centre was appropriately resourced to ensure and assure the effective delivery of appropriate safe care and support to all five residents. The staffing business case and risk assessment included a requirement for additional administration resources to ensure the effective administration and oversight of the service.

While the person in charge described how they had explored with residents feedback they had provided about their service, this feedback and the response to it needed to be explicitly explored and included in the formal systems of quality assurance.

Judgment: Not compliant

Regulation 30: Volunteers

There were centralised arrangements and procedures in place for the selection, training and supervision of persons who provided care and support to residents but who were not directly employed by the provider. The person in charge confirmed that they had the authority to supervise such persons.

Judgment: Compliant

Quality and safety

Based on what the inspector observed and discussed with residents it was evident that residents liked their apartments, valued both the independence that they had and the support provided by staff and, enjoyed a good quality of life. However,

some residents were of an older age profile and individually and collectively residents had needs that presented risk to their overall safety and wellbeing. The provider was responsive to these needs and risks but much improvement was needed in the systems and processes in place to ensure that they adequately and effectively underpinned the safe delivery and oversight of the service.

For example, there was a known history of incompatibility and while these residents no longer lived together a pattern of peer to peer incidents had re-emerged. For example, in June 2022 a staff member had reported that one resident was looking through the windows of their peer's apartment and told staff that they did not like their peer. However, while further incidents had occurred and they were responded to, there was no risk assessment or protection plan in place.

In addition, while there was evidence of regular access to and input from psychiatry, psychology and, the inspector was advised that a positive behaviour support plan was in place, the plan was dated from 2018. The plan had been reactivated in 2022 but not updated. The plan did not reflect the resident's current living arrangements and needs.

In the context of residents needs the provider was carrying a current medium to high level of residual risk associated with these needs. For example, risk assessments for residents living semi-independently had an orange medium risk rating. Both residents had a pattern of not responding to the fire detection and alarm system; this also had a medium orange risk rating. It was not adequately and robustly evidenced that controls appropriate to the levels of risk that presented were in place or consistently in place. For example, the timely completion of staff training and appropriate strategies to promote resident evacuation.

The apartments were fitted with fire safety measures such as emergency lighting, a fire detection and alarm system and doors with self-closing devices designed to contain fire and its products. There was documentary evidence available to the inspector that these systems were inspected and maintained at the required intervals. However, in the context of the challenges that presented and the staffing arrangements in the service, oversight of the effectiveness of the evacuation procedures was not adequate.

Regulation 10: Communication

The residents who met with the inspector were effective communicators. Residents engaged comfortably with the inspector and gave a good account of their daily life and routines. Residents had access to a range of media and spoke of their enjoyment of particular television channels and programmes. Assistive devices were provided where needed. For example, one resident was provided with devices to promote their ability to respond to the fire alarm in the context of a sensory deficit. With regard to positive behaviour support one resident did have particular communication supports to ensure that communication did not act as a trigger for or escalate anxiety. The requirement for up-to-date guidance in this regard is

addressed in Regulation 7: Positive behaviour support.

Judgment: Compliant

Regulation 11: Visits

Residents were free to receive visitors. As appropriate to their individual circumstances residents had ongoing contact with family and were supported to visit family members. One resident was looking forward to a visit from a sibling.

Judgment: Compliant

Regulation 13: General welfare and development

These findings are qualified somewhat by the findings in relation to staffing and the requirement for an updated positive behaviour support plan to ensure the evidence base of the support provided. However, residents spoken with presented as happy with the opportunities that they had to be meaningfully active and occupied in their local community and to participate in activities that they enjoyed. Residents for example volunteered with local organisations and attended weekly mass as they wanted to. Residents could maintain their friendships and relationships and, if it was in line with their preferred choices and abilities, residents had opportunities to pursue further education and training. The person in charge was currently meeting with each resident on an individual basis to review and agree their personal goals and objectives. Residents signed their plans to confirm their participation in their plan. Residents said that they could choose their own goals.

Judgment: Compliant

Regulation 26: Risk management procedures

Based on the assessed needs of the residents, associated risks and the current staffing levels and arrangements the provider was, based on the suite of risk assessments seen, currently carrying a high level of residual risk. For example, in relation to residents living semi-independently, non-compliance with the evacuation procedures and, SLT requirements and recommendations. Based on these inspection findings, the provider did respond to incidents and risks and did have controls in place such as MDT input and a range of restrictive practices. However, the provider did not adequately demonstrate that all risks were identified and assessed or that it had all of the controls in place to prevent and manage risk to an acceptable level so

that residents were at all times safe. For example, its staffing levels and arrangements, the completion of training by staff as requested, the provision of an up-to-date positive behaviour support plan and protection plan, effective oversight of its evacuation procedures and, effective implementation of its infection prevention and control plans.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had measures to reduce the risk of inadvertently introducing infection to the service. The provider also had measures for monitoring resident wellbeing each day so that symptoms were detected and responded to in a timely manner to prevent the spread of infection. However, on the day of inspection these measures were not followed and the providers outbreak plan was not implemented where there was a clear indicator that they should have been.

Judgment: Not compliant

Regulation 28: Fire precautions

Two of the five residents were unpredictable as to whether they would respond or not to the fire detection and alarm without prompting and guidance from a staff member. Based on the records seen there was at least one occasion for each resident where they had not evacuated in the past twelve months most recently in January 2023. However, this may not have captured all occurrences as the names of the residents who participated in the drills were not always recorded by staff. The records of the simulated drills and the individual personal emergency evacuation plans (PEEPs) did not reference any strategies that could be used or that were used by staff members to promote either resident to evacuate, particularly when there was only one staff member on duty. The PEEP's were not updated to reflect the findings of the simulated drills or corrective actions needed. These residents lived together in an apartment that was not staffed by night. No simulated drill seen tested the ability of one staff member on sleepover duty to evacuate all five residents from the four apartments.

Judgment: Not compliant

Regulation 6: Health care

While these findings are qualified somewhat by the failing above in relation to infection prevention and control, the person in charge ensured that residents had access to the clinicians and services that they needed. For example, the person in charge had sought recent reviews for residents following incidents that had occurred such as repeat speech and language therapy (SLT) assessments. Nursing advice and care was available from community based nursing resources. Healthcare plans were in place in response to assessed healthcare needs and staff maintained records of the care and support provided. For example, staff recorded the fluids and meals provided and logged the repositioning of a resident so as to protect their skin integrity.

Judgment: Compliant

Regulation 7: Positive behavioural support

While there was evidence of recent review and input from psychiatry and psychology a current and accurate plan to guide staff and to best support a resident to manage their anxieties and behaviours was not in place. The resident had in late 2022 displayed behaviours that created a significant risk to their own safety. A restrictive practice was implemented in response to these incidents. The resident also displayed behaviours at times that impacted on their peers. The plan provided to the inspector had been implemented in 2018, archived and reintroduced into practice in February 2022. However, the plan had not been reviewed and updated and was not an accurate reflection of the resident's current needs and circumstances. For example, the plan was framed in the context of a shared living arrangement that was no longer in place.

Judgment: Not compliant

Regulation 8: Protection

Two residents had a history of not living compatibility together. The residents no longer shared an apartment but they did live in close proximity to each other and verbal incidents had occurred since at least July 2022 based on records seen. However, there was no risk assessment or appropriate protection plan in place as provided for in the providers own safeguarding procedures.

Judgment: Substantially 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 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Hazel Grove OSV-0004638

Inspection ID: MON-0033881

Date of inspection: 21/03/2023

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: The registered provider will ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of residents, the statement of purpose and the size and the layout of the designated center by: • Staffing levels have been further risk assessed in terms of the differing assessed needs of residents, the number of residents, associated risks relating to the residents and the design and layout of the DC. This risk assessment was reviewed and discussed with the staff team, senior management team, and the residents. • Business case has been submitted to HSE for 70 additional hours weekly to provide additional direct support, for preferred activities/ assessed needs of residents; and to increase administration time, and oversight and management of the DC. • Interim measure will be implemented while awaiting funding – increase of 35 hours per week, with immediate effect (expected to be implemented by 31/05/2023 – recruitment in progress). This will ensure appropriate staffing levels, while awaiting approval of the business case, to further increase staffing levels in light of upcoming resident finishing course (Aug 2023), and anticipated cessation of CE scheme supports (Aug 2023). • Action plan in progress, as outlined below (under regulation 26: Risk management) relating to two residents remaining unsupervised at night to ensure both resident's needs are being appropriately met, and both resident's quality and safety of life is supported and promoted with sufficient staffing levels and resources. • Community employment scheme continues to remain in place as an additional support to one resident who at times can have increased anxiety and requires some additional support. • Resident, and staffs' feedback has been further discussed, and remedial action taken – with consideration given to this feedback when planning the immediate enhancement of staffing levels by 35 hours per week, from 9am-4pm Monday-Friday. • Resident's respective weekly schedules are under review along with overall DC weekly schedule and associated administrative requirements; as part of roster enhancement to ensure resident's varying needs and preferences are met.	

• All staff will refresh their knowledge of the organization's Code of Conduct. (Planned completion date: 30/04/2023) (Overall planned Completion date: 30/08/23; pending approval of business case by HSE).

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Person In Charge will ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. This will be ensured as follows:
• The Person In Charge will ensure that staff training is kept up to date and will continue to review staff's attendance and compliance during supervisions and performance enhancements.
• The Person In Charge will ensure that staff members required refresher MAPA practical session and Medication Management is completed.
(Planned completion – 31/05/2023).
A risk assessment is in place, with regard to the staff member being outstanding in said trainings, in the interim.
• The Person in Charge and Community Manager discussed the importance of staff training, and staffs' responsibilities in relation to their training at staff team meeting on 30/03/2023. Staff have been made aware that they will be removed from the roster, where there is non-compliance with mandatory and site specific training.
• Training matrix will be reviewed comprehensively, each quarter going forward.
• Supervision and appraisal schedule in place, and supervision will be enhanced as required in response to issues of non-compliance.

(Overall planned Completion: 31/05/2023).

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Failings in the governance and management systems within the designated center will be addressed and remedied as follows to ensure compliance with regulation 23:

• A comprehensive Risk register review has commenced, to adequately identify risks relating to the resident's varying needs, and associated risks; to ensure controls in place address them sufficiently.
• Risk assessment created in relation to Safeguarding issues between two residents.
Immediate action taken following HIQA Inspection – completed 21/03/2023.
Safeguarding Protection plan was put in place in response to incidents that had occurred – completed 23/03/2023.
• The Person In Charge sought an assessment of DC/ resident-specific fire procedures in place, with external, appropriately qualified professional. Corrective actions reviewed and action taken in relation to same. [Complete: 03/04/2023]

• PIC will revise evacuation procedures, based on external Fire Safety professional's assessment. Any corrective actions in relation to fire will be taken in a timely manner to ensure the quality of service and safety of all residents. (Planned Completion: 31/05/2023).
• Site-specific Fire Safety training has commenced with the staff team (Commenced: 03/04/2023) and will be attended by all staff; and residents. (Planned completion: 31/05/2023)
• PIC & Community Manager met with two residents who are sharing an apartment, to discuss their long-term wishes with regard to their living circumstances – both residents were clear in their wish to remain residing in the DC. This will continue to remain under regularly review, in light of their wishes, and also their assessed needs. (Completion date: 31/12/2024; or sooner if resident's needs deem immediate action is required)
• One resident will be supported to engage the National Independent Advocacy Service, as they do not have natural family supports.
• As outlined above under regulation 16- Training and Staff Development the Person In Charge will ensure appropriate oversight of Staff Training & Development and will ensure that all staff remain in date with training - this will be ensured via team meetings and individual supervisions and performance enhancements.
• The Person In Charge will ensure that all incidents and accidents are responded to in a timely manner and controls put in place to manage any risks. Incidents and Accidents quarterly analysis will be completed at the end of each quarter and sent to senior manager for further oversight. (Planned completion: Quarterly).
• The Person In Charge has further reviewed resident's annual feedback with residents and has incorporated this into the annual review and actions are outlined for completion. (Completed).
• The Person In Charge will ensure that Health & Safety & Fire Safety is added as a standing agenda item for advocacy/ house meetings to facilitate residents raising any safety concerns.
• The Person In Charge will attend and visit this topic quarterly with all residents to assess if they feel safe in the Designated Centre, and to ensure they understand their responsibilities in relation to Fire Safety, and the impact not adhering to Fire Safety regulations may have on their tenancy.
• The Person In Charge will ensure that Safeguarding remains on agenda at all team meetings and residents house/advocacy meetings.
• The Person In Charge will ensure that the easy read safeguarding policy is discussed with residents at least 6 monthly and residents watch the Safeguarding film twice a year.
• The Person In Charge will ensure staff are knowledgeable of the Safeguarding policy and implementation of same - A review of each type of abuse to be discussed at team meetings and how to response/report any suspected or confirmed incidents of abuse in a timely and appropriate manner and immediate actions that are required to be taken.
• The Person In Charge will ensure that Positive Behaviour support plans are reviewed within an appropriate timeframe and updated to provide clear, accurate, comprehensive and procedural information to staff about the type and frequency of interventions that can be used in different situations to be able to respond to behaviors of concern to ensure residents receive safe and effective services. (Planned Completion: 30/07/2023).
• HIQA inspection report, and expected standard of staff practice discussed with team at team meeting on 30/03/2023, by PIC & Community Manager.
• PIC & Community Manager continue to meet monthly, as part of PIC's mentorship programme – agenda items include Governance & Mgmt., Staff Mgmt., Person-Centered

Planning, Health & Safety, and Professional Development.
• Actions relating to Staffing, are outlined above under Regulation 15 & 16.
• The Registered Provider will at all times going forward, ensure that management systems are in place in the designated center to ensure that the service provided is safe, appropriate to resident's needs, consistent, of good quality service and effectively monitored.

(Overall Planned Completion: 30/08/2023, in line with approval of business case; & Completion date: 31/12/2024 regarding reviewing resident's long-term goals with respect to their housing).

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider shall ensure that there are systems in place in the designated center for the assessment, management, and ongoing review of risk, including system for responding to emergencies. This will be ensured as follows:
• A comprehensive risk register review for the service area inspected is in progress, to adequately identify the deficits in relation to the systems failures to date and a plan is to be put in place to address these deficits sufficiently ensuring all residents are receiving a safe and effective service.
• Open/monitoring risks have been further reviewed and comprehensively assessed including: overall staffing levels/changing needs of residents, living semi-independently, SLT requirements and recommendations, individual's safety at night while remaining unsupervised, outbreak of fire and non–compliance of evacuation procedures, training compliance by all staff, Safeguarding, IPC, behaviors of concern for one resident who requires further review with positive behavior support. The above risks have been actioned and escalated where relevant and remain under regular review.
The overall review will ensure all risks are appropriately identified and assessed, well managed/controlled and any additional controls required are identified and actioned in a timely manner. (Planned Completion: 30/06/2023).

• New Restrictive Practice put in place in relation to two residents with high level risk of choking who are unsupervised at night – Door alarms are to be fitted on 3 presses and fridge in their apartment on a 1-month trial basis, alerting staff at night to monitor if any of the residents when unsupervised are accessing food. This restriction also includes both residents not having access to food in their apartment that is not in line with SALT recommendations. (Completed - 03/04/2023). Restrictive practice protocols have been devised, and signed off by relevant multi-disciplinary team members, and have been discussed with the staff team.
• Restrictive practices have been comprehensively reviewed with the removal/reduction of some RPs, where there is no longer a risk, or where the risk now requires enhanced controls.

• Immediate action in progress for additional staff to be on-site between the hours of 9am-4pm Monday to Friday to ensure residents safety and to ensure that all residents

get to complete their daily activities as per their preferences. This resources will remain in place until approval received from HSE for additional 70 hours' weekly business case. (Planned completion: 30/08/2023)
• All staff are to have completed Feds/Dysphagia training prior to working with both residents. Any new staff will be fully inducted and trained before working with either resident alone.
• Training session scheduled for current staff team and residents at risk of choking, to ensure they are aware of the risk and how to respond.

• Fire drill completed with minimum staffing and maximum capacity as a night time drill to ensure all residents can evacuate safely. (Completed: 06/04/23). This drill was carried out in line with revised evacuation procedures, as recommended by external professional. All residents were successfully evacuated in line with revised emergency procedures.
• Fire Officer, PIC & Community Manager discussed the importance of evacuating on sounding of the alarm, with both residents who have previously not complied with evacuation procedure; this was completed as part of a site-specific training session on Fire Safety. (Completed 03/04/2023).
• Further visit to the fire station to be arranged for residents. (Planned completion 30/06/2023).
• Fire to remain as a standing agenda item on all resident/house advocacy meetings and PIC to discuss same with residents quarterly.
• Fire Safety easy read booklet to be devised and discussed with residents; and night time checklist to be devised in easy read format to educate residents on fire safety measures. (Planned Completion: 30/04/2023).

(Overall Planned Completion: 30/08/23).

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The service provider will ensure that residents are protected by adopting the infection prevention and control procedures consistent with the standards for the prevention and control of any infectious disease.

• The PIC & Community Manager met with the staff team to ensure staff are aware of their responsibility to report any suspected infectious disease immediately and their responsibility to implement the outbreak plan and any action required to contain any infectious disease to safeguard all other residents and persons. This will remain an agenda item at team meetings going forward. The Person In Charge will ensure that the outbreak management plan/infectious diseases and IPC is discussed in detailed including different scenarios when an outbreak may occur and read in detail each scenario and appropriate response at team meetings so staff are aware of exactly what to do in this instance.
• All staff will refresh their knowledge of the site-specific isolation/ outbreak plan, and the organization's Covid-19/ IPC procedure. (Planned completion date: 30/04/2023)
• Where required, staff members have been requested to refresh their IPC related

training.
• Individual meeting held with staff members where required, under the Grievance & Disciplinary Procedure. (Complete)
• The Person In Charge has reviewed Infection prevention and control training records and ensured all staff are up to date. (Complete)
• HIQA Self-assessment tool continues to be reviewed quarterly, PPE spot check audits completed bi monthly by PIC.
• PIC will continue unannounced visits to the designated center.
• IPC audits will continue to be completed six-monthly, or more often if required.

(Overall planned Completion: 30/04/2023).

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated center and bringing them to a safe location. This will be ensured by:

• Fire drill completed with minimum staffing and maximum capacity as a night time drill to ensure all residents can evacuate safely. (Completed: 06/04/23). This drill was carried out in line with revised evacuation procedures, as recommended by external professional. All residents were successfully evacuated in line with revised emergency procedures
• A comprehensive review of fire drills from 01/01/2021-Present was carried out, by the Community Manager. Recommendations arising from this review, are in progress. This review was discussed with the team at the most recent team meeting.
• Fire Drill Schedule revised to ensure appropriate numbers of a minimum of three drills per year are achieved including all staff and residents and different scenarios to be used. (Completed).
• Any corrective actions to be taken following a drill are incorporated into the fire drill and actioned in a timely manner – fire drill reports are updated to reflect corrective actions taken.
• The Person In Charge sought an assessment of DC/ resident-specific fire procedures in place, with external, appropriately qualified professional. Corrective actions reviewed and action taken in relation to same. [Complete: 03/04/2023]
• All staff on the team will carry out a fire drill. (Planned completion 31/05/2023).
• The DC's fire procedure will be updated to reflect the revised evacuation procedure for all residents; following a recent fire assessment of the evacuation plan/CEEP by a suitably trained and qualified professional. (Planned Completion (31/05/2023).
• Site-specific Fire Safety training has commenced with the staff team (Commenced: 03/04/2023) and will be attended by all staff; and residents. (Planned completion: 31/05/2023)
• Fire Safety will remain an agenda item at all team meetings and at resident's house/advocacy meetings including a review of evacuation requirements when alarm sounds. (Planned Completion: Monthly)
• Fire will remain under regularly review by the Person in Charge at all times. A SCW on the team will be assigned delegated responsibility for oversight of Fire safety checks/drills/actions require locally.

• The Person in Charge and Community Manager discussed Fire Safety at staff team meeting on 30/03/2023. A further team meeting will be scheduled following completion of site-specific Fire Safefy training by all staff, to reflect on learning, assessment recommendations and revised procedures. • The Person In Charge will ensure that there is sufficient detail on all fire drill records going forward, describing what apt the fire was in, what staff/residents participated and what level of support was required for each resident to evacuate and if residents were advised of where the fire is. • Fire Officer, PIC & Community Manager discussed the importance of evacuating on sounding of the alarm, with both residents who have previously not complied with evacuation procedure; this was completed as part of a site-specific training session on Fire Safety. (Completed 03/04/2023). • Staff to continue to educate residents on fire safety and arrange a further trip to the fire station for all residents to increase their knowledge and awareness. This education will also be explored for two residents within their POMS. • Risk assessment in relation to Fire Safety and emergency evacuation will be reviewed regularly to ensure appropriate controls in place to manage the risk. (Overall Planned Completion: 31/05/2023)

Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • The Person in Charge will ensure that there is a current and accurate plan in place to guide staff on how best to support residents with anxiety and behaviors and that it is reviewed in appropriate timeframe. • Immediate action taken following HIQA inspection: PIC made a referral to positive behavior support team requesting review of BSP for resident with increased anxiety and behaviors of concern. (Complete) • The PIC has completed a risk assessment in relation to the resident's behaviors of concern, and the provider will ensure that every effort will be made to identify and alleviate the cause of the resident's behaviors of concern. PIC to ensure that controls are in place to manage the risk and continue to monitor. (Complete) • Psychiatry review requested, and held for affected resident – complete: 07/04/2023. • Restrictive practices in place for one resident due to behaviors of concern and the level of risk involved with the behavior. RP protocol reviewed with clinical psychology oversight – complete: 30/03/2023. The Person In Charge will ensure that this Restrictive Practice is returned quarterly to HIQA and discussed with resident. (Planned Completion: 30/04/2023). • The Person In Charge will ensure that all staff are trained in positive behavior Support and safety intervention training. (Overall planned Completion: 30/06/2023).	

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection:	

• Immediate action taken following HIQA inspection: Safeguarding protection plan for resident put in place by designated officer. Visit from designated officer to two residents in relation to recent concerns and Risk assessment compiled in relation to safeguarding concerns in relation to incidents from two residents in the previous year. (Completed 23/03/2023).
• The Person in Charge will ensure that Safeguarding remains an agenda item at all team meetings and definitions of abuse are discussed and staff responsibilities to respond to any suspected/confirmed allegations of abuse.
• All staff booked on refresher face to face safeguarding training. (Planned Completion: 31/08/2023).
• All new staff to be inducted fully and aware of safeguarding measures/ plan in place.
• Privacy film to be fitted on one resident's windows, to ensure her privacy from another resident. (Planned Completion: 31/05/2023).
• Staff continue to educate residents in relation to Safeguarding - Safeguarding to be discussed at resident's house/advocacy meeting and the Person In Charge will attend quarterly to ensure residents are happy and feel safe in their home.
• Easy read safeguarding policy reviewed with all residents and Safeguarding film watched by all residents (Completed 04/04/2023).

• Behavior support referral completed for one resident in relation to behaviors of concern – referral included request to support resident to respect other resident's privacy. (Completed).
• Principal Clinical Psychologist to continue to meet with resident on a regular basis.

(Overall Planned Completion: 31/08/2023).

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/08/2023
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.	Substantially Compliant	Yellow	31/05/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	30/08/2023

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	30/08/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	30/08/2023
Regulation 23(3)(a)	The registered provider shall ensure that	Not Compliant	Orange	31/12/2024

	effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/06/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the	Not Compliant	Orange	30/04/2023

	Authority.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	31/05/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/06/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/08/2023