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:	The Ash
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	08 June 2022
Centre ID:	OSV-0004759
Fieldwork ID:	MON-0034790

About the designated centre

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

This centre is located in a residential area on the outskirts of the busy town; the location facilitates access to a range of services, shops and recreational opportunities. The premises is a bungalow type residence consisting of 2 distinct units respectively known as 'The Front House' and 'The Apartment'. The front house provides accommodation for two residents and one resident resides in the apartment. The centre operates fifty-two weeks of the year providing wraparound residential and day supports for residents with low to high support needs in the context of their disability, dual diagnosis and, other needs such as physical and health needs. The services and supports provided are based on the principles of individualised service design and, are tailored specifically to meet individual needs as identified by the person-centred planning process. Residents are supported by a staff team comprised of social care workers and support workers. Management, oversight and the general operation of the centre is provided for by the social care workers under the direction of the person in charge who has overall responsibility for the day to day management of the service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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
Wednesday 8 June 2022	10:15hrs to 18:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken to follow up on the findings of the last HIQA (Health Information and Quality Authority) inspection of this centre so as to monitor the provider's compliance with the regulations. The inspection findings were not satisfactory and did not reflect a service that was effectively and consistently managed and overseen. In addition, there were resident needs that were complex and required effective collaborative working between services as appropriate to the clinical diagnosis. While resident access to services external to the centre was in place the provider was not satisfied the service that was provided was meeting resident needs.

The inspector was based in the main house and had the opportunity to meet all three residents and the staff team supporting them on the day of inspection. Three residents live in this designated centre and their needs and living arrangements are very diverse. One resident communicates by gesture and manual signing. The resident used a sign that clearly communicated the resident remembered having previously met with the inspector. The inspector saw how the resident used the visual staff rota to confirm with staff which staff member was due to come on duty that evening. The resident relaxed in the sitting room, had a key to their bedroom door and accessed their room as they needed and wished throughout the day. One resident primarily used physical interventions such as physically guiding others to follow them. This can be challenging for staff to manage in certain situations. Staff maintained a discreet presence as the inspector allowed the resident to guide them to a particular room where the resident showed the inspector some personal items they had recently purchased. The resident then selected the items they wished to wear that day and happily returned to the staff team.

A horse-riding class had been scheduled for the day of inspection but staff said they changed this due to the poor weather forecast. Instead, two residents and two staff members went to a local sporting facility in the hope that they might meet or see the team in training practice. While this did not happen, on their return to the house one resident by gesture and sign communicated to the inspector how much they had enjoyed the trip and their lunch out. One staff member on duty had supported both residents for a significant period of time. The atmosphere in the main house was relaxed and there was an easy rapport observed between the staff members on duty and both residents.

The inspector met with the third resident privately in their own annexed apartment. The resident was receptive to a request from the inspector to meet and the resident spoke with the inspector for a period of time. With due regard for resident privacy what the inspector observed and what was discussed will be presented in general terms in the body of this report.

The inspector did not meet with any resident representatives. A recent internal review completed by the provider found feedback from representatives was not

included in the 2021 annual service review.

While the main house presented as homely and comfortable some areas were clearly in need of maintenance and refurbishment.

The deficits in governance and the complexity of resident needs impacted on the quality and safety of the service and the quality of life experienced by all three residents living in this centre. For example, more effective collaborative working between services than that reported would have better assured the status of resident health and well-being. Resident well-being impacted significantly on the resident themselves, on the staff team and other residents due to challenging and at times high risk situations that arose. The reported deficit in collaborative working between services was not a new finding. The provider outlined to the inspector actions it had taken as it sought to secure for the resident appropriate access to services. The inspector was not assured the designated centre and the arrangements in place were suited to meeting the needs of all residents. The provider had commenced an assessment of the compatibility of resident needs but this was an action originally committed to following an inspection by HIQA in 2020.

In general, the inspector found actions to improve and assure the quality and safety of the service were not satisfactorily progressed and addressed. Much improvement was needed in the management and oversight of risks and the management and oversight of restrictive practices. Improvement was needed in how accidents and incidents were reviewed so that possible deficits were identified and addressed so that resident safety was consistently protected. Improvement was also needed in the oversight of fire safety management systems.

Many of the findings of this HIQA inspection were already known to the provider. The provider had completed a very recent internal review of the service. That internal review had identified many of the deficits identified by this HIQA inspection and clearly set out the improvement that was needed in this service so that residents received a safe, quality service that was appropriate to their individual and collective needs.

In summary, these inspection findings did not reflect a service that was effectively managed and overseen so as to assure the service provided to each resident was safe, appropriate to their assessed needs, consistent and effectively monitored.

Based on the verbal feedback provided by the inspector of these HIQA inspection findings the provider submitted assurances to HIQA. The provider advised a quality improvement plan was developed and the person in charge and senior management were to maintain an enhanced presence in the centre to provide robust supervision and guidance to staff. Further changes to strengthen the management structure were planned. The provider reiterated its intent to advocate very strongly for the clinical support needed.

The next two sections of this report will 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

There was an agreed management structure and clarity on individual roles, responsibilities and reporting relationships. However, deficits in the management and oversight of this service meant the quality and safety of the service was not maintained to a good and safe standard at all times. There were established systems of review and the provider was collecting and reviewing data such as in relation to accidents and incidents that occurred. The provider did not however demonstrate how review, internal and external data and actions taken in response improved and assured the consistency of the quality and safety of the service. While there was oversight of the care and support provided to residents it was at times inadequate and ineffective.

For example, records seen indicated that the provider was completing at the required minimum six monthly intervals its own internal service reviews of the service. The last internal review was very recent having been completed in late May 2022. The review was comprehensive. The findings of the review were not good and actions issued under 10 regulatory areas reviewed. There were numerous individual actions issued within each area. While this reflected the transparency and robustness of the provider's internal reviews and its knowledge of what a safe quality service looked like, it also reflected the providers own evaluation of its failure to provide a well-managed, consistently safe, quality service.

The provider had taken action to improve the consistency of staffing levels and arrangements in the main house since the last HIQA inspection. A review of the staff duty rota indicated there was a second member of staff on duty each day from 10:00hrs to 16:30hrs so that both residents had one to one staff support. The waking staff night-time arrangement was still in place. However, the provider confirmed these additional staffing levels were not resourced by its funding body. The person in charge advised the inspector that given the risk and difficulties arising for staff it was challenging to retain staff in the annexed apartment. There was one vacant reoccurring shift. Every evening and night, a staff member from the main house provided support to the resident in the apartment if support was needed. However, in the context of the risk that presented to peers and fractured relationships the inspector was not assured as to how appropriate and adequate this arrangement was.

A staff training matrix was in place. The matrix included a record of the training completed by all of the staff listed on the staff duty rota. Based on the review of the matrix the majority of staff had completed mandatory, required and desired training such as in safeguarding, fire safety and infection prevention and control. There was outstanding training indicated on the matrix such as in responding to behaviours

that challenged and medicines management but the person in charge confirmed that this training was either very recently completed or it was scheduled. The matter arising was how appropriate the staff skill-mix was to the clinical diagnosis and assessed needs of residents including enduring mental health needs. The inspector was not assured how responsive and appropriate the staff training programme was to the specific needs of residents. This will be explored further in the next section of this report.

Regulation 14: Persons in charge

The person in charge was very recently appointed to the role. The person in charge had the required qualifications, skills and experience. The person in charge was very aware of the improvement needed in this service. The person in charge had other areas of responsibility and given the challenges in this service endeavoured to be present in the house at least two days each week.

Judgment: Compliant

Regulation 15: Staffing

The provider had addressed the staffing matter arising from previous HIQA inspections. However, it was challenging to retain a consistent staff team to provide support in the annexed apartment. There was one vacant reoccurring shift. In the context of the risk that presented to peers and fractured relationships the inspector was not assured as to how appropriate and adequate the overall staffing arrangements were. The inspector was not assured as to how appropriate the staff skill-mix was to the clinical diagnosis and assessed needs of residents including active and enduring mental health needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Based on the review of the training matrix the majority of staff had completed mandatory, required and desired training such as in safeguarding, fire safety and infection prevention and control. However, the inspector was not assured how responsive the staff training was to the needs of the service and how it supported staff to develop and maintain skills such as in the use of de-escalation and intervention techniques.

Judgment: Substantially compliant

Regulation 23: Governance and management

Deficits in the management and oversight of this service meant the quality and safety of the service was not maintained to a good and safe standard at all times. There were established systems of review and the provider was collecting and reviewing data such as in relation to accidents and incidents that occurred. The provider did not however demonstrate how internal and external data, review and quality improvement actions improved and assured the consistency of the quality and safety of the service. In general, the inspector found actions to improve and assure the quality and safety of the service such as from the last HIQA inspection were not satisfactorily progressed and addressed. The most recent internal provider review was transparent and robust. However, it also reflected the provider's own evaluation of its failure to effectively manage and provide a consistent safe, quality service in this centre. Concerning findings from this HIQA inspection included the failure to adequately and appropriately investigate incidents and poor oversight of restrictive practices.

The provider confirmed additional staffing levels put in place were not resourced by it's funding body.

The recent internal review found feedback from representatives had not been included in the 2021 annual service review.

Judgment: Not compliant

Regulation 31: Notification of incidents

Because there were inadequate systems in place for sanctioning, reviewing the need for and maintaining oversight of the use of any restrictive intervention, HIQA was not notified of every restrictive procedure in use and every occasion on which a restrictive intervention including physical intervention was used.

Judgment: Not compliant

Quality and safety

The evident deficits in the management and oversight of this service failed to ensure the quality and safety of care and support provided to residents was maintained to a

good and safe standard at all times. There was inadequate oversight of risks, accidents and incidents, fire safety and the use of restrictive practices. This was exacerbated by the fact that all three residents living in the centre had complex needs. The provider reported that while access to services was facilitated by arrangement with the Executive, the provider was not satisfied the service provided met resident needs. A comprehensive review of each resident's needs and requirements, the effectiveness of their personal plan, and the consistency of the support provided to them was needed. Ultimately the provider needed to decide if living in this designated centre and the arrangements in place were suited to residents' assessed needs, promoted their health and overall well-being.

One resident was in receipt of a service from the provider but was also an active service user of an external clinical service. The provider described the actions it took to ensure the resident had access to this service. Records seen by the inspector demonstrated the efforts made by the provider but also concerns held for the resident's well-being. The provider had formally advised this external service of the serious escalation in high risk behaviours, indicators of declining mental health and the ineffectiveness of support strategies used in the designated centre. This meant that on a daily basis the staff team had to be alert to the risk for and were subjected to unpredictable verbal and physical incidents. Some of this was high risk behavior including a relatively recent incident of physical aggression towards staff while travelling in the service vehicle. In the first quarter of 2022 staff had reported 64 incidents of behavior towards staff, peers, visitors to the centre and in the community.

While the house was divided into two sections incidents had impacted on the other two residents. While separate, the apartment and main house were in close proximity to each other and the presence of peers and a staff team in the main house to support those peers potentially acted as a trigger for some incidents. There was an active safeguarding plan for the risk of abuse from a peer. The provider had commenced compatibility assessments.

The inspector met with the resident and based on what the inspector observed and discussed with the resident there was a clear need for the review of the appropriateness and effectiveness of the current clinical input. The residents mental health struggles were evident in their physical living environment. This was negatively impacting on the safety and quality of their day to day living arrangements. The resident had an awareness of this. This created other risks such as to fire safety, self-care and general hygiene. The resident had some insight into other behaviours, and some but limited understanding of the negative impact of these on the staff team, peers and their own interactions and relationship with the wider community. For example, the resident knew and named staff who had left the service.

Based on what the inspector observed, read and discussed there was clearly a difference of opinion between services as to the genesis of the residents well-being and behaviour and the adequacy of the clinical service provided.

Both residents in the main house also had complex and changing needs. For

example, staff reported that one resident was struggling to readjust to life following COVID-19 restrictions. Based on what the inspector read and was told, the inspector was not assured as to how the process of personal planning promoted the provision of safe, consistent effective support and care. For example, there was evidence such as in incident records, minutes of team meetings and the findings of the recent internal review, that the support provided to residents was not always consistent or in line with agreed plans and protocols. Protocols to guide staff in practice and as cited in risk assessments seen were not available for review by the inspector.This did not provide assurance as to what guided daily support and care and the appropriateness and consistency of that support and care.

No improvement was noted in the arrangements in place for the sanctioning, use and review of the use of restrictive practices. The findings of this inspection did not provide assurance that restrictive practices were at all times used as a last resort and in an evidence based manner. What was evident from this inspection was the use of other additional restrictions that had not been processed through the providers existing systems so as to assure their use. This included what was described in the service as "clinical holds" but were in effect based on an incident record seen physical interventions by staff in response to behavior and perceived risk. This descriptor demonstrated a lack of knowledge and understanding of approved physical interventions. A staff spoken with did not see the need for physical intervention and spoke of the importance of following communication and therapeutic strategies.

Despite the level of restrictions in use the inspector was not assured this always promoted the safety of residents. There was poor correlation between managing and reviewing risks, incidents, restrictive practices and protocols. The provider itself had identified this and stated the lack of clarity in risk assessments and restrictive practice protocols created a risk for accidents to residents to occur. This was confirmed from incident records reviewed by the inspector. For example, one resident had left the house when staff had left the main front door unlocked. Staff reported the resident wanted to go for a drive however staff physically "brought" the resident back into the house. This incident was not referenced in the associated risk assessment and despite this event and the ongoing use and level of environmental restrictions in place the risk assessment had been closed in March 2022. A serious incident and injury had occurred in February 2022 when a resident gained access to the kettle. The resident was restricted from having unsupervised access to the kettle. There was a concerning discrepancy between the circumstances of the incident as described in the incident record and the information submitted to HIQA at the time of the incident.

The provider did not demonstrate good oversight of fire safety arrangements including oversight of simulated evacuations. For example, despite the action that had issued at the time of the last HIQA inspection the recent internal review had found only two simulated drills were completed in 2021 and no drill was completed after April 2021. Records seen by this inspector indicated six drills were completed in February 2022. However, on closer review of these drills residents (and only two of the three residents) had participated in one of these drills. Based on the records created by staff three of these six simulated drills consisted of one staff leaving the

house themselves and recording how long this had taken. This did not demonstrate how this tested the evacuation procedure and how the provider assured itself its procedures for evacuating all residents were adequate.

Equipment such as a fire detection and alarm system, emergency lighting and fire-fighting equipment was in place. There was documentary evidence these were inspected and maintained by external contractors.

Regulation 17: Premises

The premises while homely on many levels was in need of a general upgrade. There was evidence of chipped paintwork, defective kitchen finishes, defective flooring and two chairs with damaged and torn coverings. Based on what staff said and what the inspector observed there was insufficient kitchen space to safely facilitate access and services for the main house and the apartment. This may have contributed to one incident cited above. The inspector saw that some smaller kitchen appliances were in use in the staff office to service the apartment. However, there was no sink other than the wash-hand basin in the staff toilet. While staff said they did access and use the main kitchen there was an empty food container and a set of cutlery on the wash-hand basin when the inspector arrived.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Despite the level of restrictions in use as controls to manage risks the inspector was not assured these controls always promoted the safety of residents. There was poor correlation between managing and reviewing risks, incidents, restrictive practices and protocols. The provider itself had identified this and stated the lack of clarity in risk assessments and restrictive practice protocols created a risk for accidents to residents to occur. This was confirmed from records reviewed by the inspector. For example, an incident was not referenced in the associated risk assessment and despite this event and the ongoing level of environmental restrictions in place the risk assessment had been closed in March 2022. A serious incident had occurred in February 2022. There was a concerning discrepancy between the circumstances of the incident as described in the incident record and the information submitted to HIQA at the time of the incident. While these incidents were reviewed by the provider they were not appropriately or adequately reviewed and investigated and did not adequately explore factors that may have contributed to incidents or how staff had responded. For example, non-adherence to protocols and the use of physical intervention. It was not evidenced how near misses cited on risk assessments informed the review of risks, controls and restrictive practices so as to

prevent more serious incidents that had occurred.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider did not demonstrate good oversight of fire safety arrangements including oversight of simulated evacuations. For example, despite the action that had issued at the time of the last HIQA inspection only two simulated drills were completed in 2021. Two of the three residents had participated in one simulated since April 2021. Records seen demonstrated that six drills were completed in February 2022. However, on closer review three of these simulated drills consisted of one staff leaving the house themselves and recording how long this had taken. This did not demonstrate how this tested the evacuation procedure and how the provider assured itself its procedures for evacuating all residents were adequate.

Alteration appeared to have been made to agreed escape routes from the main house. The fire procedure said there were two, the diagrammatic fire evacuation plan indicated there were three but in practice only one was indicated via the main front door. While doors designed to contain fire with self-closing devices were provided there was an evident gap between the wall and one door frame.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

In the absence of constructive collaborative working between services, challenges and "barriers" as reported by the provider, the provider needed to decide if this designated centre, the model of support, and the arrangements that the provider could put in place were suited to the individual and collective needs of all residents. There was an active safeguarding plan for the risk of abuse from a peer. The provider had commenced compatibility assessments but these were a long committed to action.

Based on what the inspector was told and read the inspector was not assured as to how the process of personal planning promoted the provision of safe, consistent effective support and care. There was evidence such as in incident records and the findings of the recent internal review, that the support provided to residents was not always consistent or in line with agreed plans and protocols. A request made for a SALT review had been progressed since the HIQA 2021 inspection but the recommendations from that review were not. Protocols to guide staff in practice and cited in risk assessments seen were not available for review by the inspector. These were important protocols relating to the active safeguarding plan and a restrictive

practice.

Judgment: Not compliant

Regulation 7: Positive behavioural support

No improvement was noted in the arrangements in place for the sanctioning, use and review of the use of restrictive practices. The findings of this inspection did not provide assurance that restrictive practices were at all times used as a last resort and in an evidence based manner. As reported in previous HIQA inspection reports a high level of environmental restrictions were in use in this centre. What was evident from this inspection was the use of other additional restrictions that had not been processed through the providers existing systems so as to assure their use. This included what was described as "clinical holds" but were in effect based on an incident record seen physical interventions by staff in response to behavior and perceived risk. This descriptor demonstrated a lack of knowledge and understanding of approved physical interventions. On reviewing the relevant positive and reactive behaviour support plans insufficient detail and guidance was provided on how staff could or should physically intervene. The inspector was advised that the use of such interventions was logged in the daily narrative notes and incident records but not a restrictive procedure specific record. This did not support effective oversight of why, how and how often such interventions were used.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for The Ash OSV-0004759

Inspection ID: MON-0034790

Date of inspection: 08/06/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The service provider will ensure the following actions are taken to ensure compliance with Regulation 15. Staffing: • The PIC will complete Compatibility Assessments for all individuals residing in the DC focusing on areas of need within each assessment. Completed. • An overall review of each individuals health care needs/fundamental needs will take place and this will provide the foundation for the staffing risk assessment to determine the appropriateness of the current skill mix. [Planned completion: 01/11/2022] • Staffing Risk assessment to be developed based on the outcome of the above assessments and required control measures to be actioned in a timely manner. [Planned completion: 01/11/2022] • Support and Supervision of all staff members to occur monthly for a period of at least 6 months in order to further enhance the skills of the staff to ensure they can support the specific care needs of the residents. [Planned completion: 31/01/2023] • The PIC will carry out an overall review of the Roster and the reoccurring vacant shift, as referenced in the body of the report and will be allocated to a staff member. Completed.	
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 service provider will ensure that the following actions are taken to ensure compliance with Regulation 16. Training and Development: • The PIC, supported by Senior Manager, will liaise with the training department to ensure that Mental Health Awareness and support training is sourced for the team. • The PIC will ensure that the appropriate training is scheduled for the team in relation to de-escalation techniques and possible required interventions. This training is to be refreshed as per the recommended guidelines by all staff. • Adequate and regular support and supervision session will take place to support staff development [Planned Completion: 30/09/2022]	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The service provider will ensure that the following actions are taken to ensure compliance with Regulation 23. Governance and Management: • The PIC and Senior Manager will developed a Quality Improvement plan for the centre to ensure that there is effective governance and oversight in place going forward. This improvement plan will also identify non-compliances and actions to be taken in different areas of the service. Completed. • The PIC and Senior Manager will develop a risk assessment based on the quality improvement required in the centre, which will clearly identity actions required to address the concerns contained within this report as well as the most recent provider lead audit. [Planned Completion: 31/07/2022] • The required approval and been sought and sanctioned to employ a full time Social Care Worker for a specific period of time, in order to lead and oversee the quality improvement required within the DC, with the support of the PIC. Completed. • Full time Social Care Worker to be appointed to the role. [Planned Completion 18/07/2022] • The PIC will ensure a full review of all Restrictive Practices will take place with the relevant multidisciplinary input. Completed.	

• All Restrictive Practices will be examined with Psychology Input in order to comprehensively review each practice with the aim of working towards reducing and/or eliminating the practice if it is safe to do so. [Planned completion: 30/09/2022]

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The service provider will ensure that the following actions are taken to ensure compliance with Regulation 31. Notification of incidents.

• As outlined under Regulation 23. Governance and Management all Restrictive practices will be reviewed with the relevant multidisciplinary input. Completed

• In line with the Restrictive Practice procedure within the organization the PIC, as well as staff, Senior Management and the multidisciplinary team are actively reviewing all the restrictive practices to possibly reduce and eliminate those which can safely be reduced/eliminated. [Planned completion: 30/09/2022]

• The PIC will ensure that all restrictive practices in the centre are reported to HIQA as per the required criteria as part of the quarter 2 2022 returns and going forward thereafter. [Planned completion: 31/07/2022]

• The PIC will ensure that all staff working in the DC are aware of the current restrictive practices in place, when they are to be used, where to record the use of these and that unplanned restrictions are not to be engaged in without the correct procedures being followed. [Completed: 29/06/2022]

• The PIC will also ensure that Restrictive practices are a standard team meeting agenda item going forward.

• The PIC will request that restrictive practice briefing/information session will be provided to the team to support them to be more aware of them and conscious of working as a team towards reducing and or eliminating restrictive practices where possible [Completed: 31/12/2022]

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The service provider will ensure that the following actions are taken to ensure compliance with Regulation 17. Premesis:

• The PIC, supported by the service manager has identified areas of the premises, as cited above, as well as additional works which are required to upgrade the DC. The Senior Manager has met with the facilities manager on site and a scope of works is currently being prepared to go to tender. Completed.

• The PIC and Senior Manager will complete a proposal to the Regional Manager for the above works to be completed. [Planned completion: 01/08/2022]

• The PIC, supported by Senior Management and Facilities will ensure that the procurement process is completed for all required works and that a contractor is appointed to carry out works. Consideration will be required as to the placement of the residents while upgrade works are being carried out – the service will strive to minimize the impact of the disruption on residents at all times. [Planned completion: 31/03/2023]

• The overall compatibility assessment for the three residents will determine the suitability of the premises as a long term housing option for each resident. Adaptions to the environment will be made based on the outcome of the compatibility actions. [Planned completion: 31/07/2023]

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• All risk assessments to be reviewed by PIC and senior management – updates inputted regarding changing needs and associated restrictive practices [Planned completion 15.07.2022]
• Review date for risk assessments and restrictive practices October 2022.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The service provider will ensure the following actions are taken to ensure compliance with Regulation 28. Fire Precautions:
• The PIC will ensure that there are a minimum of 3 fire drills completed in the DC per year – one of these drills being a night time/early morning drill carried out by 1 staff to

demonstrate that the DC can be successfully evacuated on minimum staffing levels. [Planned completion – 31/12/2022]
• The PIC will ensure that individuals take part in 3 drills per year. [Planned completion 31/12/2022]
• The PIC will ensure that all staff are aware of the Fire Evacuation procedure in the center and participate in an actual fire drill or else simulate a drill with another staff member and accurately record this drill so it is clear it was simulated with staff only. [Planned completion 31/08/2022]
• The PIC will ensure to engage an external fire professional to review evacuation routes and ensure that all the Fire documentation is accurate and reflective of the setup of the center. [Planned completion: 15/08/2022]
• The PIC will also ensure the gap between the wall and fire door surround is repaired and the fire seal is inspected to ensure its integrity. [Planned completion: 31/07/2022]

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:
• Compatibility assessments to be completed for each individual [Completed]
• Definitive recommendations put forward in each compatibility assessment regarding placement, health/mental health interventions, MDT involvement and individual planning [Planned completion 30.09.2022].
• MDT meeting and capacity assessment taken place regarding actioning placement move for one individual [Complete]
• MDT required regarding health interventions – assisted decision making may be needed for individual [31.07.2022]
• Immediate review of each individuals personal plan with team members [Planned completion 31.07.2022]
• Individual planning to be discussed in each team meeting [Ongoing]
• Immediate intervention from SLT re communication interventions to necessitate meaningful engagement with each individual in relation to their plans [Planned completion 31.07.2022]
• Ongoing and regular supervision of staff to ensure understanding and skill set is adequate to maintain required improvements in service provision [Ongoing]

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The service provider will ensure that the following actions are taken to ensure compliance with Regulation 7. Positive Behavioral Support:

• As outlined under Regulation 23. Governance and Management and Regulation 31. Notification of Incidents all Restrictive practices will be reviewed with the relevant multidisciplinary input. Completed

• In line with the Restrictive Practice procedure within the organization the PIC, as well as staff, Senior Management and the multidisciplinary team are actively reviewing all the restrictive practices to possibly reduce and eliminate those which can safely be reduced/eliminated. [Planned completion: 30/09/2022]

• The PIC will ensure that all restrictive practices in the center are reported to HIQA as per the required criteria as part of the quarter 2 2022 returns and going forward thereafter. [Planned completion: 31/07/2022]

• The PIC will ensure that individuals and their respective representatives are aware of and consent to all therapeutic interventions present in the center. Planned completion: 31/07/2022]

• The PIC will ensure that all staff working in the DC are aware of the current restrictive practices in place, when they are to be used, where to record the use of these and that unplanned restrictions are not to be engaged in without the correct procedures being followed. [Completed: 29/06/2022]

• The PIC will also ensure that Restrictive practices are a standard team meeting agenda item going forward.

• As outlined in Regulation 16. Training and Development the PIC will ensure that the appropriate training is scheduled for the team in relation to de-escalation techniques and possible required interventions. This training is to be refreshed as per the recommended guidelines by all staff.

• The PIC will ensure that the Positive Behavior Support Plan for each individual are reviewed and updated to provide clear, comprehensive and procedural information to staff about the type and frequency of interventions that can be used in different situations. [Planned completion: 30/09/2022]

• The PIC will request that restrictive practice briefing/information session will be provided to the team to support them to be more aware of them and conscious of working as a team towards reducing and or eliminating restrictive practices where possible [Completed: 31/12/2022]

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.	Substantially Compliant	Yellow	31/01/2023
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	30/09/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/07/2023

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	01/11/2022
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	30/09/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph	Not Compliant	Orange	31/03/2023

	(d) shall provide for consultation with residents and their representatives.			
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	31/10/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/12/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/07/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each	Not Compliant	Orange	31/07/2022

	quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/09/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/07/2022
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the	Not Compliant	Orange	31/07/2022

	names of those responsible for pursuing objectives in the plan within agreed timescales.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	31/07/2022
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	31/12/2022
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	31/07/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive	Not Compliant	Orange	31/12/2022

	procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	31/12/2022