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:	Short Notice Announced
Date of inspection:	29 April 2021
Centre ID:	OSV-0004759
Fieldwork ID:	MON-0032295

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 and, 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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 29 April 2021	10:00hrs to 17:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

The three residents living in this service present with a diverse range of needs and abilities, this individuality was reflected in the organisation of the service and, in the care and support that was provided. However, while this was clearly a good service, there was much scope to make it a better service. There was evidence of improvement since the last HIQA (Health Information and Quality Authority) inspection but there were also matters that had not been satisfactorily addressed such as the completion of compatibility assessments, review of restrictive practices that impacted on peers and, the provision of consistent staffing. The failure to progress and satisfactorily conclude these matters impacted on the quality of the service that was provided. The provider needed to strengthen its governance of the centre to ensure that there was effective oversight and, a consistent, effective approach to quality improvement.

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. COVID-19 has resulted in changes as to how centres are inspected so that they can be inspected safely for residents, staff and inspectors. The inspector was able to conduct the inspection in an office annexed to the house and staff kindly altered their routines to facilitate this. However, while the inspector did spend sometime in the house itself this time had to be limited as the presence of the inspector presented a challenge and risk, where residents did not fully understand the importance of maintaining a safe physical distance from the inspector. In addition, the needs of residents included communication differences in the context of their overall and sensory disability. The inspector did however have opportunity to meet with all three residents and, to speak with the staff on duty and observe their interactions with residents.

One resident communicated by gesture and, manual signing that was at times unique to them. The resident greeted the inspector and the inspector noted that staff readily interpreted the signs used by the resident. Other than this welcome and some curiosity about the inspector, the resident continued to relax watching television while enjoying their take away coffee. The latter was in lieu of the coffees that the resident had enjoyed in the community prior to COVID-19 restrictions.

Residents living in the main house and in the apartment had access to their own gardens. A resident was in the garden completing a large artwork with staff. The interactions noted were relaxed and, the resident was clearly familiar with the staff on duty including the new person in charge who while new to this service, had previously worked with both residents in another setting. Both gardens presented as pleasant, welcoming and used spaces with evidence of seating and raised vegetable beds that were in use.

Staff consulted with one resident as to whether they would like to meet with the inspector and, the resident invited the inspector into their apartment that operates

independently of the facilities of the main house. The resident told the inspector that they loved their home and would never want to leave it and, had recently been supported by staff to complete some redecoration. The resident confirmed that the apartment was decorated to their liking and, there was much discussion of family and favourite actors prompted by the photographs on display. The resident was happy, spoke kindly of their staff team and, acknowledged the good support that they provided. The resident confirmed that they had received their first dose of vaccine and, was looking forward to meeting with friends again in their garden.

The provider did attempt to capture feedback from both residents and representatives as part of their systems of review. The communication differences mentioned above and, the circumstances of each resident limited the amount of feedback that was gathered. Feedback that was provided and seen by the inspector was positive but, also highlighted issues where respondents felt the service could be improved. For example, there was a request for speech and language therapy input and, a resident reported that the inconsistency of their support limited their choices and options.

Staff met with were informed and insightful of residents needs and, were very clear in communicating what was good about life in the centre for residents and, what would make life better. For example, the provider had since the last HIQA inspection converted the night-time staffing arrangement to a staff on waking duty. This was seen as a positive development for staff and residents. For example, staff could readily assist residents who got up at night and reduce the resulting disturbance for peers. However, there were lingering concerns as to the ongoing inconsistency that arose in the allocated staffing resources by day and, the impact that this had on resident well-being, choice and quality of life. The allocated and budgeted for staffing resources were not adequate to meet the individual, changing and increasing needs of the residents in the main house. The provider advised that the business case previously submitted to their funding body in this regard was to be re-escalated.

Staff were aware of the impact of COVID-19 on resident's lives and described how the impact varied dependent on the routines that residents had enjoyed prior to COVID-19. For example, access to a day service and the associated supportive network, access to clinical support and, social and recreational facilities were all impacted on. Staff and management described how they had advocated and escalated matters on behalf of residents, supported residents to have contact with family, to safely access their community and amenities, outdoor visits had occurred and more were planned. The provider had also created a second administration office for staff that was used by staff providing support in the apartment. This provided more administration space and reduced the number of staff who had previously shared one office, this was of added benefit in the context of measures to reduce the risk of transmission of COVID-19. However, the risk assessments that informed practice and the controls required in response to the risk of COVID-19 would have benefited from update and greater individualisation. This individualisation was needed to reflect the diversity of residents needs and, associated risk factors such as vaccination status, tolerance of a face mask and, the

ability or not to maintain a safe physical distance from others.

The personal plan reflected an ethos of care and support that sought to find balance between resident's rights and independence and, the provision of support that promoted resident safety, well-being and good decision-making. However, the provider had not demonstrated meaningful review of practices that were in use for the safety of one resident but impacted on their peer. The impact was somewhat less since the last HIQA inspection given the impact of COVID-19 restrictions and, the changing needs of residents. Reviews while undertaken did not demonstrate, what if any alternatives were considered or, the impact of staffing on both the potential to reduce restrictions and their impact.

The provider had fitted self-closing devices to the existing fire resisting doors. A very recent internal review had however, identified a requirement for three further fire-resisting door-sets.

Overall, there was evidence that this was a service focused on residents and the quality and safety of their lives. However, given the findings of this inspection, the provider needed to strengthen and consolidate its governance of this centre so that there was consistent, timely oversight and, a consistent quality improvement plan that was effectively monitored and, effectively implemented.

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

Capacity and capability

As stated in the previous section of this report, this was a good service and there was evidence of oversight and improvement since the last inspection. For example, waking night staff were now employed and, a new vehicle had also been purchased. Staff spoke positively of the management team and said that they were listened to and supported. However, the provider needed to strengthen its governance and oversight of this centre to ensure and assure that the service provided was safe, consistent and appropriate to the needs of all residents. The service was not adequately resourced to deliver on its stated objectives. The provider did not always effectively collect and use data, for example from internal reviews, to improve the quality and safety of the service.

For example, the inspector reviewed the findings and action plans of the annual review of the service for 2020 and the most recent six-monthly review completed in December 2020. The inspector noted from these that actions that had issued from the last HIQA inspection in 2020 were not satisfactorily resolved such as assurance

on staffing, the review of restrictive practices and, the planned completion of compatibility assessments; these continued as open actions still to be addressed. There were also differences and inconsistencies between the findings and action plans of both reviews, for example in relation to staffing and, the use and review of restrictive practices. There was further inconsistency noted on inspection in relation to the number of restrictive interventions in use. In addition, all staff working in the centre had not completed fire safety training or participated in an evacuation drill. The provider was facilitating on-line training for staff in the context of managing the risk posed by face-to-face training. There were other matters arising from reviews and from this inspection that required structured and consistent oversight, inclusion and monitoring in an overall service improvement plan. For example, the monitoring of the effectiveness of the care and services provided, monitoring of the role, effectiveness and, outcomes of supports such as reflective practice and, monitoring and ensuring collaborative working between services. Collectively these findings did not demonstrate or provide the level of assurance needed of structured, continuous, effective oversight and management at the appropriate level of the governance structure. This has been a challenging year for services in the context of responding to COVID-19 and, this has also potentially impacted on the completeness of audits and, the progression of actions. However, the last HIQA inspection had highlighted the lack of timeliness at times in the provider's response to matters that impacted on the quality and safety of the service.

For example, the provision of consistent, budgeted staffing for one resident was a longstanding matter in this service and, was not fully resolved. The provider advised that a business case had previously been submitted to the funding body the Health Service Executive (HSE), but needed to be escalated and, a revised business case was to be prepared and submitted. In the absence of the required resources there was reliance on other employment initiatives. No issue was raised with the inspector in relation to the quality of this resource but if unavailable on a planned or unplanned basis, sanction had to be sought and approved by the provider to replace this resource from within the provider's own staffing resources. Staff said that of late this arrangement was partly but not fully replaced. This was not a suitable arrangement and did not provide the resident with the quantity of support or the consistency of support that was needed for their well-being and quality of life. Staff spoken with clearly described the negative impact on the resident such as low mood, poor appetite and a tendency to self-harm. Inadequate staffing resources also limited the residents' choices and their independence and, this was exacerbated by the resident's own increasing needs. For example the resident liked and enjoyed accessing the community but now needed staff support for this. Their peer required 1 to 1 staff supervision at all times on the basis of their needs and associated risks. When there was only one staff on duty, staff could not provide the support needed to provide an individualised service to both residents.

As stated above a review of training records and other fire safety records by the inspector indicated that two staff who lone-worked in the service had not completed fire safety training. This had only been noted internally on the day prior to this HIQA inspection. The person in charge confirmed at verbal feedback of the inspection findings that this training would be complete by all staff by close of business on the day of inspection. This action negated the requirement to issue an immediate action

plan to the provider but again in the context of governance the deficit should not have arisen and, should have been identified and addressed. Otherwise, based on the records seen, staff attendance at training was overall complete and in date. For example, all staff had completed safeguarding training and a suite of training in response to COVID-19 such as hand-hygiene, putting on and taking off personal protective equipment (PPE) and, overarching infection prevention and control practice. In the context of the assessed needs of residents the provider should consider facilitating education for staff on supporting persons with enduring mental ill-health or a dual-diagnosis.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications and management experience needed for the role. While new to the role of person-in-charge, the person-in-charge described how they transferred their knowledge and experience from other roles of responsibility and, familiarised themselves with the requirements of the regulations. The person in charge had other areas of responsibility but was satisfied that they had good support from management and, from the lead social care worker in each area.

Judgment: Compliant

Regulation 15: Staffing

The provision of consistent, budgeted staffing for one resident was a longstanding matter in this service and, was not fully resolved. The existing arrangement was not a suitable arrangement and did not provide the resident with the quantity of support or the consistency of support that was needed for their well-being and quality of life.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to a programme of mandatory, required and desired training. The training programme was responsive to new challenges and risks such as COVID-19. Deficits in attendance were addressed during this inspection.

Judgment: Compliant

Regulation 23: Governance and management

Given the findings of this inspection, the provider needed to strengthen and consolidate its governance of this centre so that there was structured, consistent, timely effective oversight and, a consistent quality improvement plan that was effectively monitored and effectively implemented. The provider needed to ensure that the service was at all times adequately resourced to deliver on its stated objectives.

Judgment: Not compliant

Quality and safety

Fundamentally this a person-centred service. Staff spoken with were informed and conscientious and, clearly articulated how residents were supported to enjoy a good quality of life particularly in the context of COVID-19. However, there was scope to make this a better service and, more robust and effective governance was core to this. For example, as discussed in the previous section of this report, inconsistent staffing arrangements limited the appropriateness, individuality and quality of the service received. There was no fundamental improvement noted in the use of interventions required for the safety of residents but the use of which, impacted on their peer. There was evident infection prevention and control measures but the provider needed to review, update and individualise the risk assessments that informed the controls to protect residents and staff from the risk of COVID-19. Given the deficit that arose in fire safety training, the provider needed to ensure that it had adequate arrangements for reviewing its fire safety arrangements and, additional doors to contain fire and its products were required.

As stated at the start of this report, the three residents living in this centre presented with a diverse range of needs and abilities. This was reflected in the way that the centre was operated, for example the provision of separate and distinct accommodation and gardens. This arrangement worked well for all three residents. The personal plan informed the support that was provided. The plan reviewed by the inspector was based on the assessment of needs and choices, was up-to-date and, framed within the context and challenges presented by COVID-19. The plan demonstrated how the resident and the multi-disciplinary team contributed to the development and review of the plan. The plan reflected the delicate balance between promoting resident independence, autonomy and choice, and, resident well-being and good-decision making. The plan included the plan for responding to behaviour that was challenging, this plan was also up-to-date and had been

reviewed by the behaviour support team.

There were interventions in use that had a restrictive dimension, these were in use in response to risk that presented to resident safety in the context of their assessed needs. For example, the risk of leaving the centre without staff for residents with reduced capacity to keep themselves safe. Records seen demonstrated that review of these interventions had been undertaken since the last inspection. What the review did not demonstrate however was that these were the least restrictive options necessary to keep the resident safe, or, how the frequency and duration of their use was reduced or time limited. The reviews did not consider the impact of staffing on both the use of and the impact of these restrictions. For example rationalising the need for their continued use in the context of 1 to 1 staffing and, conversely, the impact of restrictions on peers when they did not have the staff support needed to compensate for their use. In addition, effective review and oversight was compromised by the inconsistency noted on inspection between records of the number and type of interventions in use.

Staff monitored resident health and well-being and sought to ensure that residents had the care that they needed to enjoy good health. For example, the inspector saw that this was an agenda item at staff meetings and, records seen indicated that advice and care was sought as needed from the relevant General Practitioner (GP). Screening programmes were accessed as relevant to resident age and diagnosis. Staff and management described to the inspector how access to care and treatment for a resident had been impacted by COVID-19. Management confirmed that this was appropriately escalated and dealt with by management. This was at times a challenging service to work in, Effective collaboration and a clear agreed communication pathway for raising difficulties and concerns in the service and, between services was essential to effective review and, ensuring that the designated centre and the care and support provided was suited to resident needs. For example, the staff team had concerns about changes made to prescribed treatments. Active monitoring and management at the appropriate level of the governance structure was required for matters such as this as was inclusion in the overall governance plan for the service. This is addressed in the context of governance in the previous section of this report.

The inspector reviewed the register of risks that were identified and actively managed in the service and found that overall the identified risks reflected the assessed needs of the residents living in this centre. The provider did need to review and rationalise the ongoing need for and, the proportionality of some controls; this is addressed above in the context of restrictive practices. Generally the risk assessments were reviewed on a regular basis and, this review was informed by for example, the occurrence of incidents and accidents or a change in resident needs. For example, there was a risk assessment for staff support in the community, an area where a resident had previously been largely independent. There was evidence of corrective actions taken to promote resident safety such as a review of the environment by an occupational therapist and, the provision of equipment in response to a risk for falls. However, the inspector did find that the risk assessments and hence the controls, specific to managing the risk of COVID-19 would have been better set out in an individualised basis given the diversity of resident needs and

abilities. This diversity impacted on the level of risk presented to each resident and, the controls needed in response. For example the relevance of resident vaccination status and any obstacles in this regard.

There was evidence of the core infection prevention and control practice needed in response to COVID-19 such as the monitoring each day of staff and resident well-being, the use of hand-hygiene products and face-masks and, an enhanced schedule of environmental cleaning. The person in charge confirmed adequate access to PPE and, the use of PPE as appropriate to the task and the risk that presented. There were plans and protocols for responding to suspected or confirmed cases of COVID-19.

The provider did need to improve its fire safety arrangements. For example, while regular simulated evacuation drills were undertaken, the schedule of drills needed to be responsive to for example, the recruitment of new staff. As discussed in the previous section of this report, staff were also working in the centre without having completed fire safety training. Each resident had a personal emergency evacuation plan (PPEP) that included any reluctance to evacuate. The emphasis was correctly on learning and promoting evacuation and, alerting devices were supplied to compensate for sensory disabilities. The PEEP would have benefited from inclusion of what action staff should take if the resident did not evacuate in the event of a fire. The premises was fitted with a fire detection and alarm system, emergency lighting and, fire fighting equipment. Certificates seen confirmed that these were all inspected and tested at the required intervals. Self-closing devices had been fitted to doors designed to contain fire and its products since the last inspection. However, a very recent internal review had identified a need for additional fire-resisting door-sets in the apartment and in the new staff office.

Regulation 10: Communication

Residents did have communication differences and staff spoken with were very mindful of the challenges that this presented at times, particularly where residents clearly expressed their preference to not engage with structured, formal communication strategies such as visuals and communication applications. Staff and residents were seen to effectively communicate with each other during this inspection and, staff also captured and reflected feedback from residents in the annual and six-monthly reviews. Staff identified consistent 1-to-1 staff support as a factor that most positively impacted on communication as residents with this level of support felt engaged, assured and secure. A request for speech and language therapy input as referred to in the first section of this report should be reviewed as part of the overall governance and improvement plan.

Judgment: Compliant

Regulation 13: General welfare and development

Staff were mindful of the impact of COVID -19 restrictions on residents particularly where residents had enjoyed access to their local community, shops, services, leisure and recreational clubs and, facilities and day services operated by other stakeholders. Staff supported residents to access and enjoy their local community in different ways such as preparing and taking a picnic or enjoying a take-away coffee. Outdoor visits to family and receiving visitors in the garden had recommenced. Where appropriate and in line with their wishes residents were encouraged to use technology to remain connected with life and their personal interests. Any impact on resident general welfare and development, limits or restrictions on their options and choices, is addressed in the context of staffing and Regulation 15.

Judgment: Compliant

Regulation 17: Premises

The location, design and layout of the centre was suited to the individual and collective needs of the residents. For example the premises supported two fully separate areas of accommodation and this suited residents' needs and choices. The main house also offered a choice of recreational space and, each resident had their own bedroom. The gardens were well maintained, pleasant and inviting areas that were evidently used by residents. The inspector saw that the provider had completed refurbishment works and improved the facilities provided since the last inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk assessments and hence the controls, specific to managing the risk of COVID-19 would have been better set out in an individualised basis given the diversity of resident needs and abilities. This diversity impacted on the level of risk that presented and on the controls needed in response. For example the relevance of resident vaccination status, any obstacles in this regard and, the additional associated risk that this presented.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The relevant risk assessments would have benefited from review and individualisation, this review may indicate the need for other controls or greater vigilance. However, the core policies, procedures, contingency plans and, infection prevention and control practice needed in response to the risk of COVID-19 were in place.

Judgment: Compliant

Regulation 28: Fire precautions

Given the findings of this inspection the provider needed to ensure that it had adequate arrangements for reviewing its fire safety precautions, for example ensuring that all staff attended training and participated in a simulated drill. A very recent internal review had identified a need for additional fire-resisting door-sets in the apartment and in the new staff office

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plan was based on an assessment of the residents health, personal and social care needs. The plan was the subject of review and change and, reflected the context of care such as the impact and challenges of COVID-19. The plan was developed through a person-centred approach with the maximum participation of the resident and, daily consultation about the support to be provided.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident well-being and sought to ensure that residents had access to the services and clinicians that they needed for their continued health and well-being

Judgment: Compliant

Regulation 7: Positive behavioural support

There was no fundamental improvement noted in the use of interventions required for the safety of residents but the use of which, impacted on their peer. While review of these interventions had been undertaken since the last inspection, review did not demonstrate that these were the least restrictive options necessary to keep the resident safe, or, how the frequency and duration of their use was reduced or time limited. The reviews did not consider the impact of staffing on both the use of and the impact of these restrictions.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had safeguarding policies and procedures. All staff had completed safeguarding training. All grades of staff were formally supervised. Residents presented as relaxed and confident in their environment and with the staff on duty. The person in charge confirmed that there were no active safeguarding concerns and described the staff team as invested in the safety and well-being of residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Ash OSV-0004759

Inspection ID: MON-0032295

Date of inspection: 29/04/2021

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 shall ensure that
• 15(1) 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
• 15(3) the residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis

This will be addressed by

• The PIC, PPIM and regional manager will review the previous business case submitted to the HSE, identify gaps in the roster and re escalate a revised business case to the HSE seeking funding to ensure consistency of staff supports for all individuals in the Ash. To be completed by 30/06/2021
• The PIC will update the risk assessment to reflect that when CE scheme staff are unavailable this will be reviewed with the regional manager to ensure appropriate supports are in place to ensure the continuity of care. The Regional manager will address this as an interim measure whilst still pursuing the required resources with the HSE. Completed 13/05/2021

Completed by 30/06/2021

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and

management:
The registered provider shall ensure that
• 23.(1c) 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.

The PIC will ensure this will be done by completing actions from the annual review, internal audits and Hiqa inspections in line with timelines agreed in these audits.
To ensure a consistent and timely oversight of the service the PIC will ensure the files and tracking template is updated as per template timelines and base himself in the DC throughout the week to ensure appropriate governance and oversight of the service.
Completed in line with Audit timelines as of 18/05/2021

• 23 (2) 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 plan in place to address any concerns regarding the standard of care and support.

This will be done by highlighting the need of a more robust internal audit system that reflects previous Hiqa inspections, annual reviews and internal audits. Senior management to highlight this at Quality committee meetings to ensure the quality of internal audits improves. To be completed by 28/05/2021

Completed by 28/05/2021

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider shall ensure that 26(1) the risk management policy referred to in paragraph 16 of Schedule 5, includes the following;

• The PIC is to ensure a Designated Centre risk for Covid 19 is continued and updated regularly. Completed

• The risk around Covid 19 to be more individualized. A Covid 19 risk assessment to be developed for each individual around community access and to be kept up to date going forward, specific to the individuals. Completed 19/05/2021

• A Covid 19 risk to be developed for each individual around visiting. Completed 19/05/2021

Completed 19/05/2021

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider shall ensure that effective fire safety management systems are in place by 28(2a) taking adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.

This will be achieved by completing the upgrade of fire doors and monitoring system identified in a recent internal fire audit. Awaiting responses from potential builders as part of the Brothers of Charity procurement process. Risk assessments to be updated on completion. To be completed by 30/06/2021

The registered provider shall 28(4b) 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 case of a fire.

This will be achieved by updating individuals PEEPS and the service CEEP to reflect recommendations from fire drills and internal fire audits. To be completed by 30/06/2021

Completed by 30/06/2021

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The registered provider shall ensure that 7(3) 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.

This will be achieved by following up on a recommendation in the annual review by a family member to explore Speech and Language Therapy options for their family member. A SALT Referral to be requested by the SWC in consultation with the individual and family member. To be completed by 30/07/2021

The registered provider shall ensure that 7(4) where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. The person in charge shall ensure that, where a residents behaviour necessitates intervention under this Regulation 7(5c) the least restrictive procedure, for the shortest duration necessary, is used.

This will be done by the following
• PIC and SCW to review all restrictive practice protocols currently in place. Completed 18/05/2021
• PIC to submit Hiqa notifications NF10D at the end of the quarter to adequately reflect restrictive practices in place in the designated centre. Complete by 31/06/ 2021

Completed by 30/07/2021

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	30/06/2021
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	30/06/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	28/05/2021

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	19/05/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	30/06/2021
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.	Substantially Compliant	Yellow	30/06/2021
Regulation 07(3)	The registered provider shall ensure that where	Substantially Compliant	Yellow	30/07/2021

	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.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	18/05/2021