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 Abbey
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	26 October 2022
Centre ID:	OSV-0004761
Fieldwork ID:	MON-0038042

About the designated centre

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

The centre comprises of two separate houses. In each house an individualised service is provided for one resident over the age of 18 years. Both houses are located in residential areas of a large town and transport is provided for each resident to access their local community. Each resident has access to all of the facilities offered in a residential type setting and share their home only with the staff on duty. Residents are assessed as requiring a higher level of support from staff and there are always staff on duty. Staffing levels and arrangements differ in each house based on the assessed needs of each resident. The residents are offered an integrated model of care where both day and residential supports are provided in their home. The day to day management of the centre is delegated to the person in charge supported by a social care worker in each house.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 26 October 2022	10:00hrs to 17:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken following an application made to HIQA (Health Information and Quality Authority) by the provider to vary the conditions attached to the registration of this centre. This included a condition that the provider complete certain plans within the timescale provided. The inspector found that the provider's plans though not complete were at a very advanced stage and any delay was outside of the provider's control. This had been discussed with HIQA. Overall, the inspector found that the centre was managed and operated so that residents enjoyed a good quality of life and received a service that was safe and appropriate to their needs. Some areas for improvement were identified. For example, gaps in the fire safety arrangements, assurance as to the effectiveness of the personal plan and, improvement was needed to better support infection prevention and control.

Currently the centre is comprised of two houses and accommodates a maximum of two residents one in each house. The provider had applied to add a third house and increase the occupancy of the centre to three residents. The inspector visited the new house. The house was a new build and had been finished to meet the needs of the resident who was to live in the house and, to ensure compliance with regulatory requirements. For example, it was a single storey property, occupational therapy input had been sought and provided and, equipment such as emergency lighting, a fire detection and alarm system and fire resisting doors were fitted.

There were additional infection prevention and control requirements to be considered on the day of inspection and the inspector was advised of these. Therefore, once the new premises had been inspected the inspector conducted the inspection from one of the two operational houses to reduce the risk of the accidental transmission of infection. The inspector made a brief visit to the other house once elements of the inspection process such as the review of records and meeting with the management team were complete.

The support and care observed during the inspection was person-centred, kind and therapeutic and, reflected staff knowledge of the resident and their personal plan. Both residents generally communicated by means other than verbal communication. One resident reacted with gestures of warmth and kindness to the presence of the inspector in their home. There was prominent evidence of the use of communication tools to support effective communication such as visuals, technology and sensory items. Staff were very clear on the resident's ability to understand what was said and the inspector saw that the resident could clearly communicate what it was they wanted or did not want. For example, the resident handed staff their personal tablet when they wanted to watch something or directed staff to a particular area or item. After some period of interaction the resident by gesture appeared to communicate that they wanted some space and this was respected. Staff present recognised this cue and it was also referenced in the resident's positive behavior support plan. The resident was quite content to interact again later with the inspector. There was a very easy and relaxed rapport in both houses between the staff members on duty

and the residents.

Both residents had good opportunity to remain connected with home, family, peers and their local community. For example, one resident engaged in a range of community based activities such as swimming, horse-riding, visiting a sensory library, going for walks with staff, visiting peers or receiving visits from peers. On the day of inspection the resident received a visit from a peer and went for a walk with staff.

Based on what the inspector read and discussed there was good and consistent contact with families in relation to the support and care that was provided. Family wishes and requests were respected in so far as was safe and reasonably practicable.

There were good arrangements for monitoring resident wellbeing and ensuring residents enjoyed good health. Clinical recommendations were evident in the support observed and described. For example, staff showed the inspector the utensils recommended to support the resident to drink safely and staff described how they ensured the recommendations were consistently adhered to, for example if the resident was eating out. Good safe practice was evidenced in the management of medicines.

As stated earlier the time spent in one house was limited by infection prevention and control considerations. However, the inspector was assured and staff confirmed that the facilities currently available to the resident on the ground floor were adequately meeting the resident's needs. The resident gave a warm smile when the inspector asked if it was okay to see their bedroom. Staff said that the resident was not actively seeking to access the stairs and the first floor of the house where their bedroom was previously located. The ensuite provided on the ground floor was compact and of a domestic type but was sufficient in the short-term. The inspector saw how the resident communicated to staff that they would like a drink. Staff were attentive to this request and could clearly tell the inspector what fluid intake the resident had had so far that day.

Staff were diligent in establishing inspector wellbeing before entering each house. However, while the practice observed reflected current national infection prevention and control guidance, the guidance on file was not current. The house was visibly clean but a review of cleaning procedures and equipment was needed. Space, storage and the use of the available space was a challenge in one house.

In summary, based on what the inspector observed, read and discussed this was a person centred service and the provider was progressing its plans to improve the service. As these plans were not complete this resulted in some ongoing non-compliance with the regulations. In addition, while the standard of care and practice observed was good and residents presented as well and content, there was scope for improvement.

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

Overall these inspection findings reflected a well-managed service where governance and management was focused on providing each resident with a safe, quality service and a good quality of life. The provider sought to improve the safety of the service and the provider's plan to provide more suitable accommodation for one resident was well advanced. However, there were some gaps and areas that needed better oversight as it was not always clear how information the provider had gathered was used to review and change as needed the care and support provided. For example, in relation to infection prevention and control and aspects of the personal plan.

There had been some recent changes to the management structure and further changes were planned. However, the inspector was satisfied that the arrangements put in place by the provider ensured continuity of management. For example, the current person in charge was an existing member of the management team and had sound knowledge of the plans in place to support each resident. A staff member spoken with was aware of the management changes and confirmed that they had good access as needed to the person in charge and other members of the management team. The social care worker spoken with who supported the person in charge in the management of the service had allocated administration time and was satisfied with this arrangement.

The records of staff meetings indicated that these meetings were held at the recommended frequency. There was good management and staff attendance at the meetings, good discussion of resident needs and support and, monitoring of the progress of the actions agreed at the previous meeting.

Based on what the inspector observed and discussed, staffing levels and arrangements were suited to the assessed needs of the residents. There was flexibility in these arrangements. For example, if two staff members were required to better support a medical appointment this was facilitated. Staff spoken with understood the importance of continuity and consistency for residents and, this consistency was reflected in the staff rota reviewed by the inspector.

In summary, there was evidence of effective management and oversight. However, there were areas that would have benefited from better oversight and a definitive quality improvement plan. The provider needed to ensure that there was flexibility and continuity in its systems of oversight including its quality assurance systems so as to ensure consistent and effective monitoring. The evidence to support this finding and the actions necessary will be presented in each relevant regulation in the

next section of this report.

Registration Regulation 8 (1)

The provider submitted a complete and valid application seeking variations to the conditions attached to the registration of this centre. The information submitted to HIQA was an accurate reflection of the changes the provider wished to make.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was recently appointed to the role. This was an interim arrangement and a further change was planned. The person in charge had the required skills, experience and qualifications for the role. The person in charge had solid knowledge of resident needs, plans of care and support and, the progression of these plans. Staff confirmed they had access as needed to the person in charge. The person in charge discussed their role in the mentorship programme so as to ensure continuity given the further planned change.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements were suited to the assessed needs of each resident. Staffing arrangements differed based on these assessed needs and there was flexibility in the staffing arrangements. For example, one resident had waking night staff while a sleepover staff arrangement was sufficient in the other house. The person in charge confirmed that the current staff team were to transfer with the resident to their new home thereby ensuring continuity for the resident.

Judgment: Compliant

Regulation 16: Training and staff development

The records of training completed by staff members working in the centre were provided to the inspector for review. Overall, staff had completed a broad range of training that reflected mandatory and required training requirements and residents'

assessed needs. Completed training included for example, training in safeguarding, fire safety, responding to behaviour that challenged, first aid, falls management, medicines management and specific sensory-communication training. However, based on the records provided there were two training gaps one in fire safety and one in responding to behaviour that challenged.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, this presented as a well-managed service that was focused on providing each resident with a safe, quality service that was appropriate to their needs. The centre presented as adequately resourced and, the provider's plan to improve the safety and appropriateness of the service while not met within the original timeframe, was at a very advanced stage. The standard of support provided and day-to-day oversight was good but there were some areas that would have benefited from better oversight and a definitive quality improvement plan. For example, infection prevention and control, aspects of the personal plan and fire safety. This and the improvement needed is addressed in the relevant regulations in the next section of this report.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider kept the statement of purpose and function under review and reviewed it as necessary to reflect any changes. For example, changes to the management structure and the proposed changes to the size and occupancy of the service.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had notified the Chief Inspector of a change to the role of person in charge and of the arrangements in place for the management of the centre including the appointment of a new person in charge.

Judgment: Compliant

Quality and safety

Residents were supported to enjoy good health and a good quality of life closely connected to family, peers and their local community. The provider had progressed the actions from the previous HIQA inspection and its plan to improve the safety and the appropriateness of the service were well advanced. Based on the support observed and discussed with staff and, the records reviewed by the inspector the support and care provided was of a good standard but there was some scope for improvement.

For example, the effectiveness of the personal plan would have been better assured by a robust MDT review. The personal plan reviewed by the inspector clearly set out the resident's needs, abilities and preferences and the support and care to be provided. The support observed was as set out in the plan including the progression of the resident's goals and objectives. The inspector saw the use of a visual schedule, sensory items and the provision of meals as set out in the speech and language therapy (SLT) recommendations. The plan was therefore informed by input from the multi-disciplinary team (MDT) and staff followed the plan. Family were also consulted with and their input was reflected in the plan.

However, the facilities provided included a sensory room for the resident with a range of sensory equipment. Staff reported that the resident no longer used this room and while the sensory equipment was still in place the room was cluttered and used for general storage and for the completion of some laundry tasks. Staff also reported that the resident did not engage with a recommended communication application. Staff said that this did not impact on the resident's ability to effectively communicate. The garden was spacious but with the exception of a hammock there was little of a therapeutic or sensory nature in the garden.

The personal plan included the plan for responding to any behaviours of concern; the plan was devised with behavior support input and had been reviewed in September 2021. However, when the inspector reviewed this plan the inspector saw that the plan did not comprehensively address all types of behavior that were exhibited. There was guidance for staff separate to the plan but the source of this guidance was not clear. This guidance and the practice observed was therapeutic. These behaviours and their management had also been discussed at a recent staff meeting. However, one community based activity had ceased due to these expressed behaviours and the difficulty they posed in this particular context. A staff member spoken with confirmed this and readily understood the challenges that arose for the resident, staff and others.

There were interventions in use that the provider itself had concluded were restrictions: the provider had processes for their use and review. However, clarification to support consistency was needed in relation to what constituted a restrictive practice, in part to ensure that there was clarity and consistency in notifying restrictive practices to HIQA.

The infection prevention and control practice observed and records such as risk assessments reflected current guidance. The house was visibly clean and staff were seen to attend to tasks such as the cleaning of frequently touched items. Staff members on duty wore well-fitting face masks and used PPE (Personal Protective Equipment) appropriate to the task. Staff had completed a range of infection prevention and control training that included hand-hygiene, the use of PPE, how to break the chain the infection and, training in cleaning and disinfecting practices. However, practice would have benefited further from an infection prevention and control quality assurance plan.

As stated the new house was a new build, finished to a high standard and to meet the assessed needs of the resident and, regulatory requirements such as fire safety. One other house was also fitted with emergency lighting, a fire detection and alarm system, fire-fighting equipment and doors designed to contain fire and its products: the doors were fitted with self-closing devices. However, one house was still without fire resisting doors at first floor level. Some improvement was also needed in the arrangements for ensuring residents could be evacuated and brought to a safe location.

Regulation 10: Communication

While staff reported that a resident choose not to engage with a recommended communication application this did not appear to limit the residents ability to communicate with staff. There was evident use of other tools such as technology, visuals, a visual daily routine and sensory items. Staff readily recognised gestures used by residents to communicate their needs and wishes.

Judgment: Compliant

Regulation 11: Visits

Residents had good access to home and family and could receive visitors in their house. There were reasonable controls to ensure that visits could be safely accommodated. For example, staff members who supported other peers to visit the house adhered to infection prevention and control requirements. There were no restrictions on visits other than when this was deemed to be a risk to residents, staff or others.

Judgment: Compliant

Regulation 17: Premises

One house was still unsuited to the assessed needs of the resident living in the house. Changed needs had reduced the associated risk as the resident was now provided with ground floor accommodation and was reported to be currently content with these arrangements. Based on what the inspector observed and on what staff reported, these arrangements were suited in the interim until the resident relocated to their new house. Their long-term suitability however was limited.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector reviewed the register of risks and saw that it reflected for example, the assessed needs of the resident. The review of risks and the existing controls was regular. There was a good link between the occurrence of incidents and accidents and the review of risks and their control. For example, the risk to resident safety and the effectiveness of the existing controls to manage that risk were reviewed and updated following SLT review.

Judgment: Compliant

Regulation 27: Protection against infection

Infection prevention and control practice would have benefited from better oversight and a quality improvement plan. For example, storage space was limited and there was no appropriate storage area for the mop buckets and handles which were stored in the hallway. Storage limitations limited the full application of the colour coded cleaning system as outlined in the providers infection prevention and control policy. The sensory room was used as a general storage area and was also used to dry laundered clothing and linen. The majority of the guidance on file in the COVID-19 folder was out of date and retired. For example, guidance on visits was dated from 2020 as was guidance for staff on the wearing of surgical masks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

One house was still without fire resisting doors at first floor level. In the other house staff undertook simulated evacuations with the resident. The resident required prompting and guidance from staff to evacuate but readily evacuated for staff.

However, drill reports stated that while the resident willingly left the house they also re-entered the house despite staffs' best efforts to prevent this. There were no identified actions seeking to address this and this risk was not reflected in the resident's personal emergency evacuation plan.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed the management of medicines in one house and found that there were good systems that supported safe practice. Medicines management practice was in line with the providers own medicines management policy. For example, any over the counter medicines were used following consultation with the gp and staff maintained a record of their administration.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

An MDT review of the resident's personal plan in particular the sensory dimension of their needs and supports was needed. This was needed to assure decisions that were made, to ensure that the service continued to grow and change with the resident and, all alternatives were considered before any aspect of the residents routines and activities was limited. Staff reported that the resident no longer used the sensory room and generally did not engage with a recommended communication application. There was little of a sensory or therapeutic nature provided in the garden.

Judgment: Substantially compliant

Regulation 6: Health care

The personal plan included the plan for assessing and supporting any healthcare needs that residents had. Staff maintained a record of all referrals, advice given and care provided from services such as the resident's general practitioner (gp), SLT, occupational therapy, clinical nurse specialists and hospital based services. Monitoring records seen confirmed the staff team implemented recommendations such as the monthly monitoring of resident body weight.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour support plan did not comprehensively address all types of behaviour that were exhibited and how these should be managed and responded to. Clarity to ensure consistency was needed in relation to what constituted a restrictive practice. Revised guidance issued by HIQA in 2018 clarified the role of resident autonomy and control when deciding if a clinical intervention was a restrictive practice or not. If these elements of choice and control were not in place then the intervention was a restrictive practice and therefore should be viewed as such and notified to HIQA. Interventions in use that indicated there was possible inconsistency included devices used as part of a seizure management plan and, an alarm fitted to a door to alert staff that the door may have been opened by a resident.

Judgment: Substantially compliant

Regulation 8: Protection

Staff training records confirmed that all staff had completed the face-to-face refresher safeguarding training that was part of a wider safeguarding and governance quality improvement plan. This training had been outstanding at the time of the last HIQA inspection.

Judgment: Compliant

Regulation 9: Residents' rights

The person in charge confirmed that an MDT review of a personal care procedure had taken place since the last HIQA inspection. While the practice continued as a last resort a protocol was put in place setting out clear guidance for staff on establishing resident consent or not to the procedure. The person in charge reported that the procedure did not happen if the resident did not indicate their consent.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 8 (1)	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Abbey OSV-0004761

Inspection ID: MON-0038042

Date of inspection: 26/10/2022

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 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 the following actions are taken to ensure compliance with Regulation 16: Training and Development: • The PIC has reviewed the training records of the staff member and identified that the Management of Actual and Potential Aggression training is booked for 13/12/2022. • Fire Safety training to be booked and completed by the staff member. [Completed] The training Matrix for the area will be reviewed by the PIC in December 2022 to identify all refresher training required for 2023 and this data will be communicated with the Social Care Worker and individual staff members for 2023 to ensure all training requirements are actioned appropriately throughout 2023. [Planned completion: 31/12/2022]	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The service provider will ensure the following actions are taken to ensure compliance with Regulation 17: Premises: • Alternative accommodation has been identified for one resident. [Completed] • Transition plan to be completed to support the resident to become familiar with and spend time in the new location. [Completed] • Sensory OT input to be sought to ensure the décor of the new property is in line with the resident's sensory needs. [Completed] • The above accommodation is currently near completion with furniture and fittings and	

the transitioning of the resident to spending time in the location will commence. [Planned completion: 5/12/2022 – Transition plan to be commenced there after]
• The PIC will strive to ensure that the transition will successfully take place in as timely manner as possible while taking into account the residents feelings/reaction to the new property. [Planned completion: 31/12/2022]

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The service provider will ensure the following actions are taken to ensure compliance with Regulation 27: Protection against infection:
• The PIC will review the Covid-19 folder and ensure all the guidance documents are relevant and in date. [Completed]
• Procurement for an outdoor shed/storage area to be completed. [Completed]
• There is identified repair works to be completed on the fencing at the back of the property. A scope of works is required for same. [Completed]
• The registered provider is required to liaise with the neighbor regarding the cost associated with the repairs to the fencing due to it being a shared fence. Awaiting feedback from the identified neighbor regarding same. [Planned completion 10/12/2022]
• The PIC will ensure the shed is delivered as soon as the fencing is completed and it will be utilized as additional storage space for mops to allow the full implementation of the color-coded system as per the local Infection Prevention and Control Procedure, as well as items currently being stored in the Sensory Room. [Planned completion: 31/03/2023]
The PIC to review the Infection Prevention and Control Risk Assessment to ensure that all current IPC measures in place are appropriate and adequate. [Completed]

Regulation 28: Fire precautions	Substantially 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:
• In the event that another individual is to be identified to live in the current Designated center that one resident is transitioning out of, and it is deemed suitable for the this individual's needs, the fire resistant doors will be installed in the property prior to the commencement of service.
• The PIC will ensure that the one residents PEEP is reviewed to ensure that information is outlined regarding the possibility of this resident re-entering the property and that all

strategies to avoid this happening are also outlined. [Completed]
• The PIC will ensure that the Fire Risk Assessment is also updated to reflect the outcome of the Fire Drill where by the individual attempted to re-enter the house following evacuation. [Completed]
• An additional Fire Drill to be scheduled to assess the residents reaction and all corrective actions to be noted on the PEEP and associated Risk Assessment. [Planned completion: 15/12/2022]

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The service provider will ensure the following actions are taken to ensure compliance with Regulation 5: Individual Assessment:
The PIC will ensure that a Sensory OT referral is made and input is sought regarding the overall Sensory needs of the individual – there is OT input currently in place as well as sensory suggestions however a specialized Sensory OT will be engaged with to ensure the needs of the resident are being met. [Planned completion 31/01/2023]

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The service provider will ensure the following actions are taken to ensure compliance with Regulation 7: Positive Behavior Support:
• The Positive Behavior Support Plan to be reviewed with the newly appointed Behavior Support Therapist. Due to the absence of the long standing therapist and a lengthy delay in securing a replacement the team are awaiting confirmation of the allocation of the therapist. The request for the review has been escalated via the Psychology department. [Planned Completion: 31/01/2023]
• The PIC will ensure that going forward the multidisciplinary recommended restrictive practice regarding the seizure management plan is reported to HIQA each quarter. [Planned completion – 31/01/2023]
• The PIC will ensure that the Risk Assessment for the newly installed door alarm is in place as well as the associated Restrictive Practice Protocol with the relevant multidisciplinary input. This restriction will be notified to HIQA each quarter. [Planned completion – 31/01/2023]

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/12/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are	Substantially Compliant	Yellow	31/03/2023

	protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	15/12/2022
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.	Substantially Compliant	Yellow	31/01/2023
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,	Substantially Compliant	Yellow	31/01/2023

	and are reviewed as part of the personal planning process.			