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:	No.2 Brooklime
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	23 September 2021
Centre ID:	OSV-0005129
Fieldwork ID:	MON-0029791

About the designated centre

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

A full-time residential service is provided in this designated centre for a maximum of nine male adults. The designated centre comprises of two houses, less than one kilometre apart, on the outskirts of a town outside Cork city.
One house is a bungalow, set on an elevated site with panoramic views over-looking the harbour. Up to five residents can live in this house. The other house is a detached, dormer-style house which can provide residential supports for up to four adults. Although they are part of the same designated centre, the two houses are run entirely separately. There is a social care leader assigned to each house and the staff teams are entirely separate.
Residents in the centre have been diagnosed as functioning in the range associated with moderate to severe levels of intellectual disability, including those with autism. The centre is staffed at all times.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 23 September 2021	09:20hrs to 19:10hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

All eight residents who met with the inspector appeared happy in their homes and to have positive relationships with the staff supporting them. The inspector spent the majority of the inspection in one of the houses in the centre. There had been a recent period of poor management oversight by the provider in this house which resulted in some of the identified non-compliances with the regulations. The same issues were not identified in the other house in the centre.

This was an unannounced inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection. This centre was comprised of two houses located within a kilometre of each other. It was explained, and was evident, that both houses were run entirely separately. The person in charge was responsible for the centre. One social care leader and staff team were allocated to each house. The inspector spent the majority of the day in one of the houses, visiting the second house for approximately two hours prior to providing feedback on the inspection in the provider's local head office.

The inspection began in the larger of the two houses, where five residents lived. There were two staff working in the centre when the inspector arrived. Both staff had worked overnight in the centre, one remained awake and the other did a sleepover shift, where they could be woken to provide additional support, if required. The night-time staffing arrangement was the same in both houses. At approximately 09:30 a staff member that usually works in a day service arrived. The inspector was informed that a day service staff member worked in this house from 09:30 to 16:00 four days a week. This additional staff was allocated to the house as, prior to the pandemic, four of the five residents usually attended day services. The fifth resident, who was retired, occasionally attended day services to attend social events. At the time of this inspection, the residents had not resumed attending day services. The person in charge advised that discussions were underway to address this but there was no agreed return date.

The inspector was informed that in the week prior to this inspection, the social care leader based in this house had returned to work on a phased basis following a period of extended leave. When asked who had fulfilled their duties in their absence, staff told the inspector that long-serving staff working in the house had taken on responsibilities such as organising the roster and facilitating regular staff meetings. Staff also mentioned that another social care leader had briefly worked in this house. Later, the person in charge told the inspector that another social care leader had been assigned to work in this and one other house but that arrangement was short-lived. At the time of this inspection the person in charge fulfilled this role for five designated centres and was about to take on this role for a sixth centre. The person in charge informed the inspector that they spent time in both houses in this centre every week. The findings of this inspection indicated that greater management oversight was required in this house, especially in the absence of the

management staff usually based there. Given this was not provided, the inspector was not satisfied that the person in charge could ensure the effective governance, operational management and administration of this centre.

On arrival, the inspector met briefly with two residents who were in the kitchen. One resident had finished their breakfast and another was still enjoying theirs. Later in the morning the inspector had the opportunity to meet with all five residents. Residents spent time in their bedrooms, the kitchen and the sitting room. One resident also came into the office at various times while the inspector was there. The residents appeared happy to meet with the inspector. One resident showed the inspector a book that had been given to them by relatives. Others interacted with the inspector verbally, using gesture and, using Lámh (a manual sign system used by people with intellectual disability and communication needs in Ireland). The residents appeared at ease in their home and comfortable with the support provided by staff. Three of the residents were supported to go out with the day service staff, returning prior to the inspector going to the other house in the centre. The inspector overheard two residents engaging in an activity and interacting with friends from their day service using video-conferencing. It was clear that they thoroughly enjoyed this activity.

It was clear that staff and residents enjoyed positive relationships with each other. As various staff arrived to the house throughout the inspection they were warmly and enthusiastically greeted by the residents. All interactions observed were warm, respectful and unhurried. Staff were able to understand the residents' unique ways of communicating with them. When speaking with the inspector, staff demonstrated a good knowledge of residents' interests, support needs and what was important to them.

A staff member showed the inspector around the house. Each resident had their own bedroom and these were decorated in line with their personal tastes and preferences. The rooms were clean and bright and had family photographs on display. It was possible to get a sense of each resident's personality and interests from how their rooms were decorated and what they chose to keep in them. Three residents had bedrooms with an ensuite bathroom. Two residents did not. The inspector went into one of the ensuite bathrooms and observed that it required cleaning with dust in the extractor fan and mould visible on the ceiling and shower seal.

It was outlined in the January 2020 Health Information and Quality Authority (HIQA) inspection report of this centre that works were due to start in this house to provide a bathroom which would meet the assessed needs of the residents. At the time of this inspection, these works had not taken place. The inspector was informed that this delay was caused by the COVID-19 pandemic. A staff member advised that the facilities manager had recently been in the house and works were planned for one resident's ensuite bathroom. The person in charge later advised that these works would make the bathroom more accessible for this resident but they would still not be able to shower there. There was one communal bathroom in the house. Access to bathroom facilities had been raised by one resident when asked about their satisfaction with the service. It was documented that at times the bathroom was in

use when they wanted to use it.

Although not apparent in the bedrooms, it was clear that storage was an issue throughout the rest of this house. Some food was stored in the laundry area rather than in the kitchen. In the office, which was also the bedroom for sleepover staff, boxes of personal protective equipment (PPE) were kept on the floor, duvets that were not in use were rolled up in the corner of the room and a laundry basket with items in it was placed on top of a filing cabinet. The inspector also saw boxes containing files and documents in the hot press. Areas of the house also required cleaning and re-painting. Damaged surfaces were also noted on counter tops and an external door. When the areas requiring maintenance were raised with the person in charge, they informed the inspector that the social care leader had raised these issues with them on the day before this inspection.

As outlined previously, on arrival to the house staff were observed to be implementing enhanced infection prevention and control measures. These included wearing masks, maintaining interpersonal distance where possible, and regularly washing and or sanitising their hands. Staff had also taken the inspector's temperature and were observed taking their own. HIQA had been informed that a resident in the centre had been referred for a COVID-19 test by their general practitioner (GP) in September 2021. This test had subsequently been completed & the results received. In the course of this inspection, it became clear that public health guidance and the provider's own contingency plan in the event of such a scenario had not been implemented. When raised with the person in charge, they advised that they felt that the test was a precaution on the GP's part and that as the resident did not have a temperature and had recently experienced chest infections they did not consider it was necessary for the resident to isolate from their peers, or implement the other additional precautions. This approach was not consistent with protecting residents from healthcare-associated infections, including COVID-19.

The inspector also spent time in the other house in this centre. While there, the resident met with the social care leader and met briefly with two other staff and the three residents living there. Another resident had moved out of this house in January 2021. The person in charge informed the inspector that due to this resident's changing needs, another designated centre was assessed as more suitable for them. This move was reported to have been a success and the resident had settled in very well to their new home. This resident had lived in a self-contained apartment in this house. Building works had recently been completed to open up what had been the self-contained living area to the rest of the house. This had created a second sitting room for the residents. On the day of the inspection, two of the three residents were spending time in this room and appeared very much at ease. The inspector asked that the floor plans reflecting all of the recent changes be submitted to the HIQA registration team.

The second house was decorated and maintained to a very high standard. Parts of the outside area were being painted when the inspector arrived. New outdoor furniture had been bought and the inspector was told that residents liked to eat outside when the weather allowed. The house was clean, bright, colourful and modern. One of the residents had celebrated their birthday on the day prior to the

inspection and banners and balloons were still decorating the dining room. The house had recently been repainted and some minor touch ups were required following the moving of some items as part of the reconfiguration of the house. This work was planned. There was a very calm atmosphere in the house and the creation of a second living area meant that residents had another room, other than their bedrooms, to spend time away from their peers if they wished. Residents had their own bedrooms and these were decorated in line with residents' tastes and in keeping with the overall decoration of the house. Residents appeared very at ease in their home and comfortable with the support provided by staff. One resident appeared slightly unsettled by the inspector's presence. Staff supported them to cope with a new and unfamiliar person in their home. The third resident was out on the inspector's arrival but introduced themselves on their return and was very welcoming. They showed the inspector out at the end of the inspection and kindly opened the door for them as they left.

None of the residents in the centre had returned to attending day services at the time of this inspection, although a reintroduction was planned for one resident the following week. Through discussion with staff in the first house visited by the inspector, and on review of this group of residents' recent activities, it was evident that they had not been supported to return to community-based activities in line with the easing of national lockdown restrictions. One resident had a goal to go on social outings. The documented reviews over a 12 month period repeatedly referenced that the resident was unable to access the community for social activities. The exceptions to this were visits to relatives' homes and a reference to going for coffee outdoors locally with a relative on one occasion. The person in charge acknowledged that staff were protective of this group of residents given their age and healthcare needs. It was not clear to the inspector that this approach had been suitably risk assessed for each of the five residents living in this house. The social care leader was aware of this issue and advised that the need for residents to return to community living had been raised in the annual multidisciplinary reviews. By contrast, on arrival to the other house one resident was out doing grocery shopping with a staff member. When activities were discussed, staff informed the inspector that they had booked cinema tickets as soon as it was possible to do so as this was a preferred activity, missed by the residents. Documents reviewed showed that the easing of restrictions was regularly discussed at staff meetings in this house.

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 to each resident living in the centre.

Capacity and capability

The provider needed to further improve the overall governance and management

structure of the centre in order to ensure effective oversight and the delivery of a sustainable and consistent service to the residents in both houses.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. Support staff in each house reported to the social care leader, who reported to the person in charge, who reported to the person participating in management. It was evident throughout this inspection that the person in charge delegated many of their responsibilities, as outlined in the regulations, to the social care leaders. As stated in the opening section of this report, when a social care leader was required to take a period of extended leave the person in charge did not arrange for a suitable replacement or provide the required management oversight themselves. This lack of oversight is reflected in the findings regarding governance and management, training and staff development, records, premises, individualised assessment and personal plan, and complaints identified during this inspection. The inspector met with the recently returned social care leader and from discussion and a review of documents in that house, it was clear that they had identified many areas requiring improvement and initiated plans to address them.

There was a consistent staff team working in both houses in the centre. This ensured that residents received a continuity of care and were supported by teams of staff who knew them well. There were planned and actual staff rotas in place.

The provider had completed an annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre, as is required by the regulations. Action plans were developed to address any issues identified. On the day of this inspection it was evident that actions had been completed or were being progressed. Residents and their representatives had been consulted as part of the annual review and for the most part their feedback was very positive. A relative reported to always feeling welcome in the centre and another made reference to how their relative was always respected and never had cause for complaint. Relatives commented on how happy and content residents were and were positive about the support provided by staff.

A finding from an unannounced visit to the centre in June 2021 was that most staff's mandatory training was up to date. The inspector reviewed the available training records in one of the houses. It was clear that this record had not been maintained in the absence of the social care leader. From the document provided to the inspector, gaps were identified in training in fire safety, managing behaviour that is challenging, safe administration of medication, and epilepsy management. There was no reference to the training completed or required by two staff members working in the centre. The social care leader was aware of this issue and since their recent return had requested the required information so as to update the training record and then identify and arrange any required training. Of most concern was the finding that four out of nine staff required refresher training in epilepsy management. One of the residents in this house had epilepsy, was prescribed emergency medication to treat it, and had required hospital care for this medical condition in recent months. When reviewing that resident's file, it was noted that the training issue had been highlighted to the provider's training department in March

2021 however it was not documented if there had been any follow up on this in the social care leader's absence. Staff supervision had not been completed at the frequency outlined in the provider's policy in this house.

The person in charge spoke with the inspector about a number of other audits and checks regularly completed in the centre. Areas monitored included medication, infection prevention and control, and any adverse incidents in the centre. The person in charge advised that medication audits occurred four times a year in each house and one of these was completed by a pharmacist. There was only one medication audit available for one of the houses in 2021. It was noted in a staff meeting on the day prior to this inspection that the pharmacist was to be contacted to facilitate the next, overdue, medication audit.

The complaints log for one of the houses was reviewed. There were two complaints made on behalf of the same resident, one in August 2020 and another on 21 August 2021. Both of these complaints were written by staff on behalf of the resident. The complaint made in August 2020 was resolved in December 2020. The more recent complaint was escalated to the person in charge on 06 September 2021. At the time of this inspection, on 23 September 2019, any subsequent investigation or actions taken to address this issue had not been documented. It was also not documented if the complaint was resolved or of the complainant was satisfied.

The paperwork in some residents' files required review to remove outdated documents and to ensure that the information was accurate and up to date, for example, some weekly routines referenced going to day service although the resident had not attended since March 2020.

Regulation 14: Persons in charge

The person in charge was responsible for five centres and could not ensure the effective governance, operational management and administration of this designated centre.

Judgment: Not compliant

Regulation 15: Staffing

The number and skill mix of the staff was appropriate to the needs of the residents. Both houses had a consistent staff team who knew the residents and their support needs well. The documents, specified in Schedule 2 of the regulations, were not examined during this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff required training in fire safety, managing behaviour that is challenging, safe administration of medication, and epilepsy management.

Judgment: Substantially compliant

Regulation 23: Governance and management

The oversight arrangements in place for a period of extended leave of a key member of the management team in one of the houses was insufficient. As a result the management systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that all of the required information was accurate.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A complaint made in the centre had not been investigated in a prompt manner. It was unclear what, if any, follow up had taken place regarding this matter and the complainant had not received any documented response more than one month after the complaint was first made.

Judgment: Not compliant

Regulation 21: Records

Not all records in relation to each resident had been accurately maintained.

Judgment: Substantially compliant

Quality and safety

Residents enjoyed living in both houses in this centre. There was evidence that residents' healthcare needs were well met and they were supported to maintain strong family relationships. Improvements were required in one of the premises and in the planning and review of residents' personal goals. Improvements were also required to ensure that all of the residents living in the centre were supported to participate in the community in line with their own wishes, while also adhering to national public health guidance and the provider's own policies and procedures relating to the ongoing COVID-19 pandemic.

The inspector a reviewed a sample of residents' personal plans in each house in the centre. These included a life story summary which provided key information about the person's personal history and the important people in their lives. All plans included a review involving multidisciplinary professionals completed in the last 12 months.

Residents' healthcare needs were well met in the centre with timely and appropriate access to general practitioners, specialist consultants and allied health professionals, as required. Where a healthcare need was identified, a corresponding plan was in place. It was noted in one resident's healthcare management plans that the signs and symptoms were the same in a number of plans although they did not cross-reference each other. It was therefore not clear which plan should be implemented if the resident were to present with the described symptoms.

There was evidence of collaborative work done with an allied health professional to support residents who found injections and blood tests difficult. Work had also been done to support a resident to gain independence in an area of personal care. It was reported that this achievement had had a knock-on effect of improving this resident's overall wellbeing.

Personal plans also included plans to maximise residents' personal development in accordance with their wishes, as is required by the regulations. These plans varied in the number of goals and some contained goals more typically contained in healthcare plans. Residents' goals were reviewed quarterly. The quality of these reviews also varied. It was often not possible to tell what, if anything, had been achieved to meet residents' goals since the last review. In the review of some goals, there was reference to an inability to progress due to the COVID-19 pandemic rather than these goals being reimagined into a related goal that was achievable. Of the sample reviewed, one of the residents did not have a current plan. This had been discussed at a recent staff meeting and the social care leader also discussed it

with the inspector. It was planned to arrange a meeting for this resident in the near future to develop their plan.

As referenced in the opening section of this report the five residents living in one house had not been supported to re-engage with community-based activities in line with the easing of the national lockdowns imposed as a result of the COVID-19 pandemic. For example, some residents who enjoyed having a sociable drink had not been to a pub in 18 months. When asked if residents were going into shops, the person in charge was unsure. Activities for residents in this house largely involved drives and visits to outdoor areas such as parks. This was not the case in the other house where residents were involved in everyday household activities such as grocery shopping and other community-based activities in line with their own interests and preferences, such as going to restaurants and the cinema.

All residents who wished to do so had met with family members in recent months. Most often residents met with their relatives outside of the centre. Not all residents had family living locally and one resident spoke with the inspector about an upcoming visit to stay with a relative in Dublin.

As outlined in the first section of this report the premises in one house required significant improvement to ensure it met residents' needs, was well maintained, and had suitable storage facilities. The other house was maintained to a very high standard and had been recently painted and decorated. There was a very low level of restriction throughout the centre. A restrictive practice had recently been removed from one of the houses.

There was a supply of varied, fresh and nutritious food available in both houses. When reviewing the food stored in one of the houses, it was noted that the dates that some refrigerated products were opened was documented. This was not the case for all foods. Where they were required, staff had a good knowledge of residents' individualised feeding, drinking and swallowing difficulties (FEDS) plans. Copies of these plans were also available in the kitchen area for reference, if required, during food preparation and mealtimes. Residents also had access to adaptive equipment, where assessed as necessary.

The fire precautions in one of the houses were reviewed by the inspector. Systems were in place and effective for the maintenance of the fire detection and alarm system and emergency lighting. Residents all had personal emergency evacuation plans (PEEPs) and these had been recently reviewed. Fire drills were completed regularly and included a recent drill with night-time staffing levels.

Staff were observed implementing enhanced infection prevention and control (IPC) measures. IPC self-assessments had been completed in each house. There was also evidence that monthly audits in this area were completed by members of the staff team. However, as previously outlined, when a resident was referred for a COVID-19 test by their GP, national public health guidance and the provider's own policy and contingency plan were not implemented.

Regulation 11: Visits

Residents were free to receive visitors if they wished. Due to the ongoing COVID-19 pandemic, there were specific guidelines in place to facilitate visitors if requested.

Judgment: Compliant

Regulation 13: General welfare and development

While residents had opportunities to participate in activities, in one of the houses in this centre they were not supported to participate in community-based activities in line with their preferences and current national public health advice.

Judgment: Substantially compliant

Regulation 17: Premises

These findings only relate to one house in the centre. This house was in need of maintenance. It was also identified that one resident's ensuite bathroom required cleaning to remove mould. As this was described as a longstanding issue by the person in charge, the ventilation also required review in this area of the house. There was insufficient storage for household items. There was also an insufficient number of showers and toilets to meet residents' assessed needs.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was a supply of varied, fresh and nutritious food available in both houses. Staff were aware of and skilled in providing support to residents with additional assessed needs in the area of eating and drinking.

Judgment: Compliant

Regulation 27: Protection against infection

National public health guidance and the provider's own policy and contingency plan were not implemented when a resident was referred for a COVID-19 test by their general practitioner.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire detection and alarm systems and equipment were available in the centre. Drills had been completed in both houses. All residents had a recently reviewed PEEP in place. Some staff member required training in fire safety.This was addressed under Regulation 16.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of the health, personal and social care needs of each resident had been completed. Each resident had a personal plan. Improvements were required to the development and review of residents' goals. One resident did not have a currrent plan regarding their personal development.

Judgment: Substantially compliant

Regulation 6: Health care

Healthcare was provided in line with residents' assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Not all residents who required one had a recently reviewed behaviour support plan in place. Referrals had been made to request these.

Judgment: Substantially compliant

Regulation 8: Protection

There were no active safeguarding concerns in the centre at the time of the inspection. Any previous concerns had been addressed in line with national policy and the provider's own procedures.

Judgment: Compliant

Regulation 9: Residents' rights

Documents and files containing residents' personal information were stored in the hot press of one of the houses.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	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	Substantially compliant

Compliance Plan for No.2 Brooklime OSV-0005129

Inspection ID: MON-0029791

Date of inspection: 23/09/2021

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The Provider will • Address the increased workload of the Person in Charge due to the development of a new Centre to support a relocation of residents from this Centre to a newly registered Centre. The Provider is in the process of recruiting an additional Persons in Charge in the Provider Governance and Management structure. This will reduce the number of Centres assigned to the Person in Charge and will also facilitate the Person in Charge to work alongside the team to provide greater operational governance. [28/02/2022] - Until such time as the revised structures are in place the Provider will ensure that the Person in Charge and the Team Leader are supported in meeting all regulations including implementing the identified areas requiring improvement such as training and staff development, records, premises, individualized assessment and personal plan and complaints.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge will ensure that - All staff in the Centre are identified on the Training Matrix - All staff have access to all appropriate training including refresher training on a timely	

basis.
- An updated training needs analysis has been submitted to the training department which has identified training requirements for the Centre.
- Training is on the agenda of staff team meetings fortnightly to ensure training issues are monitored on an ongoing basis.
- The training department sends emails weekly to remind staff that they have been booked for specific trainings coming up in the following weeks.
- Training has been booked for MAPPA, Epilepsy Management and Fire Safety training. Dates will be scheduled by the training Department at earliest opportunity having regard to the fact that the availability of face to face training remain reduced according to public health guidelines [28/02/2022]

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider will ensure that the system of Governance and oversight includes the following key controls:-
• The Person in Charge visits the Designated Centre at least once a week and is in daily contact via the phone and emails as necessary.
• The Person in Charge receives a Weekly Service Area Report of all significant issues.
• The Person in Charge meets with the Team Leaders weekly
• The Person in Charge has monthly Team Leader meetings, which in turn contributes to the agenda of the local staff meetings. The PIC will attend local staff meetings as necessary.
• The Person in Charge attends all Annual Multi D Reviews, Restrictive Practice Sanctioning Meetings and reviews.
• The Person in Charge has a Compliance Checklist that ensures monitoring of regulations.
• The Person in Charge has regular supervision meetings and contact with the Sector Manager.
• The Person in Charge attends monthly meetings with the Service Provider in relation to compliance with regulations.
• The Provider has a system of unannounced six-monthly visits and a schedule of audits to be carried out in the Designated Centre. These audits cover all Regulations. The Sector Manager and PIC discuss outcomes and action plans from these audits at regular meetings throughout the year to supplement the six monthly-visits.
- If the Team Leader is on extended leave, alternative arrangements will be put in place to maintain the protected time afforded to support the operational running of the Centre. This time off-roster will be reallocated to an experienced Team member to ensure continuity of supports for the Person in Charge.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Provider will issue to the Authority, the revised floor plans to reflect the swap of dining and sitting room areas in the front of the Centre.
The statement of Purpose and Function as updated in June 2021 will been reviewed and updated where necessary. [30/11/21]

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Provider will ensure that all complaints made at a local level will follow the complaints pathway as stated in Provider Complaints Process.

All complaints, where possible, will be resolved locally in the residential Centre in the first instance and escalated via the formal complaints process as necessary.

All actions pertaining to a complaint made will be documented on the complaint form including a note on the satisfaction or otherwise of the complainant with the outcome of the process.

In relation to the complaint made on behalf of a resident on the 6/9/21 the following actions have been made.
• A review of the complaint took place with the PIC and SCL on the 29/9/21
• Contact to made with Psychology to review the disdat tool to determine psychological effects if any, on the complainant
• Continuous MDT involvement is in place in relation to the other Person Supported
• MDT reviews will monitor suitability of placement for Person Supported in the Centre
• Control Measures are in place to offer reassurance to the complainant and these are reviewed fortnightly at staff meeting.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records: All records pertaining to each resident have been stored securely and archived as appropriate. 4/11/2021

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development: General Welfare and Development will remain a standard item on staff meeting agendas. With the easing of public health restrictions, Persons Supported have begun engagement in community based activities in line with their will and preference. These are risk assessed to include assessing of Covid 19 risk to the individuals.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: • The Provider has ensured that the maintenance Plan identified but delayed due to COVID restrictions has been reviewed and updated as necessary • Planned Kitchen works to commence on the 6/12/2021 to be completed within a week. • The en-suite for on resident commenced 24/10/21, this is now completed • Smaller maintenance works have been completed since 7/10/21. • The inside of the house has been scheduled for painting once the larger maintenance works have been completed with a deep clean to follow. 20/12/21 • Fortnightly maintenance requests are made to the Facilities Department to manage ongoing required maintenance. • All high areas, extractor fans and shower seals have been cleaned/repaired as necessary. • Increased storage facilities will be identified and provided where necessary [31/01/2022] • The Provider is currently exploring options to create an additional accessible shower facility in the Centre. The works will be scheduled for completion by 30/06/2022

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Provider has ensured that the local COVID 19 Infection Control contingency plan has been updated to reflect updated national public health guidance.

Risk assessment was reviewed by the PIC and SCL to ensure they reflect changes in national guidance.

The Infection Prevention Control Self-Assessment tool has been updated. Actions completed on the 19/10/2021

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 Person in Charge has ensured that all Personal Profiles and Person Centred Plans have been reviewed since the inspection by the PIC and Team Leader.

Training on Personal Outcomes Planning /setting Personal Goals and Keyworker training took place with Provider Quality Standards and Learning Department on the 3/11/2021 who will liaise with individual Key Workers in the development of person centered plans for each of the residents to ensure the increased robustness of personal goals. This will be an ongoing action to support enhances Outcomes for each of the residents.

The resident that did not have a current plan at the time of the inspection has had a planning meeting on the 27/10/2021. This meeting took place with the resident, his family and keyworker as per the residents request in a nearby hotel. The plan is now in place and will be reviewed quarterly as per schedule.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge has ensured that all Behaviour support plans were reviewed on

4/10/2021 with the relevant Providers Behaviour Support Intensive Support professional. All plans in place are still valid as the functions of the behaviours have not changed.

This will be documented by Behaviour support and forwarded to residential services for PS records. 20/12/2021.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Provider has ensured that the PIC and Team Leader will complete HIQA training on Rights Based Approach by 20/11/2021. This learning will then be shared with the Team. The Provider Quality Department will support staffs skill set in developing person centred goals involving all residents. All plans will be reviewed to ensure residents wishes are facilitated wherever possible during the ongoing pandemic 30/11/2021

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 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	31/10/2021
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	28/02/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Substantially Compliant	Yellow	28/02/2022

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/02/2022
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.	Substantially Compliant	Yellow	31/01/2022
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	20/12/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	20/12/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	20/12/2021
Regulation	The registered	Substantially	Yellow	19/11/2021

21(1)(b)	provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Compliant		
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	31/10/2021
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	30/11/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the	Not Compliant	Orange	19/10/2021

	prevention and control of healthcare associated infections published by the Authority.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	19/11/2021
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	31/10/2021
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	31/10/2021
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/10/2021
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any	Not Compliant	Orange	31/10/2021

	action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	27/10/2021
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	03/11/2021
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	Substantially Compliant	Yellow	20/12/2021

	to manage their behaviour.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	30/11/2021