# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

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| Name of designated centre: | Hortlands |
| Name of provider: | Gheel Autism Services Company Limited by Guarantee |
| Address of centre: | Dublin 16 |
| Type of inspection: | Announced |
| Date of inspection: | 09 March 2022 |
| Centre ID: | OSV-0003507 |
| Fieldwork ID: | MON-0027545 |

## About the designated centre

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

Hortlands designated centre is located in a suburb in Co. Dublin and can cater for nine residents, both male and female, over the age of 18 years. The centre is comprised of three buildings. Hortlands house has five bedrooms, two bathrooms, a kitchen and a living area. Adjacent to this is Hortlands flat which has two bedrooms, a kitchen, bathroom and living room. There is a prefabricated wooden building at the end of the garden that contains two additional communal rooms for residents. Phoenix house is located in a different suburb. This is a semi-detached two story home that accommodates one resident. The designated centre specialises in providing residential services in a personalised and homely atmosphere. The designated centre has a low arousal philosophy, which is used to support adults with a diagnosis of Autism. Residents are supported by a team of social care workers and care workers. These staff are directly overseen by a location manager and a person in charge.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 7 |

# 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 9 March 2022 | 09:35hrs to 18:00hrs | Jennifer Deasy | Lead |

## What residents told us and what inspectors observed

In line with public health guidance, the inspector wore a face mask and maintained physical distancing as much as possible during interactions with residents and staff. The inspector had the opportunity to meet with the majority of residents on the day of inspection. Some residents chose to interact with the inspector in more detail and told her about life in the designated centre. Many of the residents had also completed questionnaires in advance of the inspection. The inspector used observations, discussions with residents and key staff and a review of documentation to form judgments on the quality of residents' lives in the designated centre. Overall, the inspector found that the designated centre was providing a person-centred service which was respectful of residents' rights.

The inspector visited each of the three premises which comprised the designated centre and spoke to residents and staff. The inspector saw that residents appeared comfortable and relaxed in their homes. Some residents were being supported to visit family and friends in the community or to access community facilities such as the local church as per their individual preferences. Other residents chose to stay home and were seen watching television, making cups of tea, listening to music, relaxing in their bedrooms or chatting to staff. Staff and resident interactions were observed to be friendly and familiar. The inspector saw that staff were responsive to residents' questions, comments and requests including those made through non-verbal means.

Residents told the inspector that they were happy living in Hortlands. Some residents showed the inspector their bedrooms and appeared proud of them. The inspector saw that resident bedrooms were individually decorated and furnished. Residents' goals were displayed in a visual format on their bedroom walls. Residents could tell the inspector about their goals as well as their activities and hobbies. The inspector also saw accessible information throughout the house including rights posters, a weekly timetable, the complaints procedure and hand hygiene posters. Staff could describe how they support residents who communicated non-verbally to choose activities in a meaningful way. Staff were aware of how residents communicated that they did not wish to participate in an activity and were mindful of the residents' right to do so.

Resident questionnaires detailed that residents were generally happy with the service being provided in Hortlands. The questionnaires demonstrated that residents engaged in a variety of both in-house and community based activities. These included going to church, out for coffee or chocolate, shopping, baking, listening to music and gardening.

The inspector saw that the premises of the three houses were generally clean and well-maintained. There were some minor maintenance issues required in Phoenix House. For example the laminate cover of the built-in fridge unit had been removed as it had started to peel. The provider was aware of this and had a plan in place to address this in the immediate future.

The next two sections of the report will present the findings of the inspection in relation to the governance and management arrangements in place and how these impacted on the quality and safety of care in the designated centre.

## Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and to contribute to the decision-making process for the renewal of the centre's certificate of registration. The inspector found that this service generally had effective management arrangements in place to ensure that the quality and safety of care of the service was consistently and effectively monitored. However, amendments were required to the statement of purpose to ensure it complied fully with the regulations.

The centre was run by an experienced and suitably qualified person in charge. The person in charge had worked in the service for a considerable length of time and had been in their current role for eight years. The person in charge knew the residents well and could speak competently about their needs and preferences. The person in charge had oversight for one additional designated centre. There were appropriate mechanisms in place to support them in having oversight of both of the designated centres. This included the assignment of a location manager to Hortlands. The location manager had allocated management hours and had clearly defined roles and responsibilities. The person in charge was employed in a full-time capacity and was supernumerary to the roster.

The designated centre was operating with a full staffing complement and was in line with the statement of purpose at the time of inspection. A roster review demonstrated that there were adequate staffing to meet the needs and number of residents. The inspector saw that there were sufficient staff available to support residents on the day of inspection. Staff described how they provided an individualised service for residents and informed the inspector that there were sufficient staff to do this. A review of the roster showed that a small panel of in-house relief staff were used to bridge any presenting gaps due to staff leave. This supported continuity of care for residents.

Staff reported that they felt supported in their roles. Staff were aware of some of the risks that may present to them when working in different premises of the designated centre. For example, lone working by night where residents were known to present with behaviours of concern. Staff were knowledgeable regarding the process to contact management for out-of-hours support. Staff had access to regular informal supervision through monthly staff meetings as well as more formal supervision, which was held biannually. A review of the staff meeting minutes identified that they covered a variety of appropriate topics including keyworker reports, residents needs, COVID-19 information and incident management. There was a very high standard of training maintained in the designated centre. All staff were up-to-date in mandatory training areas such as fire safety, safeguarding, managing behaviour that is challenging and COVID-19.

There were effective management systems in place to ensure oversight of the provision of care in the designated centre. There was a clearly defined management structure. The person in charge was supported in their role by an on site location manager who had dedicated management hours. The person in charge reported to a regional manager for additional support and supervision. Monthly staff meetings, location manager meetings and regional manager meetings were held to enhance oversight of the service. Action plans were developed from these meetings as required. Actions were allocated to a responsible person and were specific, measurable and time-bound. The provider had completed an annual review of the quality and safety of the service in consultation with residents and family members. Bi-annual audits of the quality and safety of care were also completed by the provider. Comprehensive time-bound action plans were developed from these audits and there was evidence of progression of actions across audits.

The centre's statement of purpose was reviewed on the day of inspection. It was found to contain much of the information as set out in Schedule 1 of the regulations. However, some amendments and additions were required. For example, the statement of purpose did not contain information as set out in the certificate of registration and the description of the rooms in the designated centre required clarification to ensure they accurately reflected the floor plans.

## Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity and was supernumerary to the roster. The person in charge had oversight of two designated centres, one of which was Hortlands. There were adequate mechanisms in place to support the person in charge in having oversight of Hortlands designated centre. The person in charge was suitably qualified and experienced.

Judgment: Compliant

## Regulation 15: Staffing

The centre had a full whole time equivalent staffing complement as per the statement of purpose. A review of the roster detailed that staffing was as per the statement of purpose and was suitable to meet the needs and number of residents. A small panel of in-house relief staff was maintained to fill any gaps in the roster. This supported continuity of care for residents.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to a high level of mandatory and refresher training. All staff were up-to-date in mandatory training at the time of inspection. Staff spoken with were knowledgeable regarding areas covered in training including infection prevention and control and fire safety. Staff informed the inspector that they felt supported in their roles. They had access to regular informal supervision through monthly staff meetings and formal supervision biannually.

Judgment: Compliant

## Regulation 23: Governance and management

The provider had in place mechanisms to ensure oversight of the quality and safety of care of the service. The centre was resourced in line with the statement of purpose and there was a clearly defined management structure that identified lines of authority and accountability. There were effective management systems in place including staff meetings, manager meetings and regular audits to ensure that the service was safe and consistently and effectively monitored. An annual review was completed in consultation with residents and family members as well as bi-annual audits of the quality and safety of care of the service. Comprehensive, time-bound action plans were developed as a result of these audits.

Judgment: Compliant

## Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose which contained much of the information as required by Schedule1 of the regulations. Some amendments and additions were required, including:

- the conditions of registration
- the number of residents for whom accommodation is to be provided
- a description of the rooms in the designated centre, including their size and primary function.

Judgment: Substantially compliant

## Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre. Overall, the inspector found the designated centre was providing a safe environment where residents' rights and autonomy were being respected. However, improvements were required to the systems in place for assessing residents' needs and ensuring that care plans comprehensively reflected the procedures for supporting those needs. Additionally, improvements were required to ensure that residents' refusals of medical interventions were clearly documented and that these were supported by capacity assessments and risk assessments where relevant.

The premises of the designated centre were generally well maintained and were laid out in a manner to suit the needs and number of residents. The premises were clean and were suitably decorated. Several residents showed the inspector their bedrooms and appeared proud of them. Residents had access to facilities for occupation and relaxation including activity rooms and gardens. Hortlands House had recently undergone refurbishment works and residents stated they were happy with how their house was renovated. While Hortlands House had limited downstairs communal space, residents also had access to a garden cabin for activities. Residents were observed using this throughout the day to listen to music and to have some time alone. The provider had a plan in place to address minor cosmetic works in Phoenix House. For example, the laminate cover of the fridge freezer unit required replacing and the floor outside the bathroom required maintenance. The inspector was informed that a new laminate cover for the fridge had been ordered and that there was a plan to address the flooring.

The provider had in place systems to contain and extinguish fires. Fire doors were in place throughout the designated centre. However, a risk was identified whereby not all fire doors closed completely on activation of the self-closing mechanisms. The provider assured the inspector that maintenance would be on-site to address this risk the day following the inspection. All staff were up-to-date in fire safety training. Residents' personal evacuation plans clearly detailed the measures required to support residents to evacuate. Staff spoken with were knowledgeable regarding evacuation procedures and routes. Regular fire drills were completed which showed that residents could be evacuated within a safe time frame.

There were policies and procedures in place to mitigate against the risk of residents acquiring a healthcare-associated infection. The premises were observed to be very clean and tidy. Staff were wearing personal protective equipment (PPE) which was in line with current public health guidance. Temperature checks and COVID-19 symptom checks were maintained of all visitors to the centre as well as for staff. There was sufficient supply of hand sanitiser and a safe disposal system for used PPE. The provider had a COVID-19 outbreak management plan in place that detailed the procedure to be followed in the event of an outbreak of an infectious disease. A COVID-19 contingency assessment had also been completed and was updated at regular intervals.

A sample of resident files were reviewed on the day of inspection. The inspector saw that, while residents had an assessment of need completed which was reviewed annually, this was not multidisciplinary in nature and did not comprehensively reflect all of residents' needs as these had changed or developed over recent years. For example, some residents had undergone assessments and had recommendations in place for management of conditions such as hernia or for feeding, eating, drinking and swallowing disorders. However, these were not reflected in the assessment of need or supported with care plans. Additionally, without multidisciplinary input from relevant health care professionals during the annual review of the assessment of need and care plans, it was unclear how the effectiveness of these plans were being evaluated.

The inspector saw that, on several occasions, staff had quickly identified that a resident presented with a health care need and had completed a referral to an appropriate healthcare professional. However, there was a lack of follow up with professionals where assessed needs had been identified. For example, one resident had been assessed as requiring a modified diet subsequent to an acute neurological episode. The speech and language therapist recommendations stated that follow-up could be provided within six weeks of the assessment in order to review the recommendation. There was no evidence that this follow-up had taken place and, therefore, that the resident was safe to resume a more regular diet, as the inspector was informed they were currently on.

Additionally, there was an absence of risk assessments and capacity assessments where a resident had refused a procedure or intervention. While the provider was clear that the residents' rights to refuse medical treatment were to be respected, the provider was unsure in some instances if residents had capacity to refuse particular interventions. The absence of a capacity assessment contributed to differing opinions between the provider and healthcare professionals. This resulted in a delay in accessing relevant medical interventions for some residents. The provider was endeavouring to engage the residents in interventions by rescheduling appointments. However there was no evidence that capacity assessments had been completed or that the impact of not having a procedure on the resident had been risk assessed.

Staff were skilled and knowledgeable in relation to managing behaviour that is challenging. All staff were up-to-date in training in this area and could competently describe how they use a low arousal and proactive approach to supporting positive behaviour. Behaviour support plans were on file for those residents who required them, however these did not comprehensively reflect the proactive and reactive strategies to be used. For example, it was recommended that one resident wear protective clothing to reduce the impact of self-injurious behaviour. On the day of inspection, the resident was not wearing this clothing. Staff stated that the resident may refuse to wear it and while they were respectful of the resident's right to do so, there was no guidance available to staff on how to respond when the resident refuses the recommendations.

The inspector saw there were three restrictive practices in place in the designated which had not been logged as such or notified to the Chief Inspector as required by the regulations. Two of these were stair gates and the third was an audio monitor which linked a resident bedroom to a staff room by night. The provider stated that these were implemented to ensure the safety of residents in line with their assessed needs. However, the impact of these on the residents' rights to privacy and to freely access all parts of the designated centre had not been considered and assessed as such.

All staff had completed training in safeguarding vulnerable persons and were aware of how to recognise and report abuse. However, there was a failure of the provider to identify and report some peer to peer incidents of abuse. The inspector saw, on a review of the incidents log, that there were three occasions in recent months where one resident had hit or allegedly hit another resident. These incidents were not reported to the Chief Inspector or to the local safeguarding team. Intimate care plans were in place for those residents who required them. These were regularly reviewed and were written in person-centred language. These plans provided detail to residents on how to support and respect residents' privacy and dignity.

## Regulation 17: Premises

The premises of the designated centre were designed and laid out to meet the aims and objectives of the service and were suitable to meet the needs and number of residents. The houses were clean and kept in a good state of repair. There were some minor premises issues in one of the houses, Phoenix House. For example, the laminate cover of the built in fridge unit had peeled off and the floor outside the bathroom had warped. The provider had a plan in place to address these issues in the immediate future. Resident bedrooms were personalised and were decorated in line with individual preferences. There was adequate storage and facilities and equipment were maintained in good working order.

Judgment: Compliant

## Regulation 27: Protection against infection

The provider had effected policies and procedures to mitigate against the risk of residents acquiring a healthcare-associated infection. The premises were clean and tidy and generally well maintained. Staff were wearing appropriate PPE and temperature and COVID-19 symptom checks were maintained.

There was a recently reviewed and updated COVID-19 contingency plan as well as a comprehensive outbreak management plan. These plans clearly detailed the procedures to be followed in the event of a suspected or confirmed outbreak.

Judgment: Compliant

## Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety management systems were in place. There was equipment in place to detect, contain and extinguish fires. Regular fire drills were completed and staff were knowledgeable regarding fire safety. However, a risk was identified whereby not all self-closing mechanisms functioned adequately. The provider gave assurances that this would be addressed as a matter of urgency.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Residents had an assessment of need on file which had been reviewed and updated within the past 12 months. However, this assessment of need was not multidisciplinary in nature and, in some instances, did not accurately reflect all of the residents' assessed healthcare needs. There was an absence of care plans to support some health care needs. Additionally, without input from relevant multidisciplinary professionals, it was unclear how the effectiveness of the assessment of need and associated care plans were being evaluated.

Judgment: Substantially compliant

## Regulation 6: Health care

The provider had ensured that residents had access to appropriate healthcare by promptly referring residents to professionals as required. However, the inspector saw, that in some instances, follow-up care with relevant professionals was not completed. Additionally, where residents had refused a medical treatment, this had not been clearly documented or risk assessed. There was no evidence that capacity assessments had been completed and this led, at times, to a difference of opinions between the provider and healthcare professionals which resulted in a delay to some medical interventions.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

The person in charge had ensured that staff had up-to-date training and skills to respond to behaviour that was challenging. Behaviour support plans were in place for those residents who required them. Behaviour support plans had been recently reviewed and updated. However these plans did not comprehensively reflect the steps to be followed to support residents to manage their behaviour.

The inspector saw that not all restrictive practices were logged as such. Therefore, it was unclear how these were being reviewed and how the provider was assured that the least restrictive procedure was being used for the shortest duration possible.

Judgment: Substantially compliant

## Regulation 8: Protection

All staff had received appropriate training in safeguarding. There were safeguarding measures in place to ensure that staff providing support with intimate care did so in line with the resident's plan and in a manner which was respectful of resident's dignity and bodily autonomy. However, the inspector saw that there were incidents of peer-to-peer abuse which had not been reported to the relevant statutory bodies and investigated accordingly.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Substantially compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Hortlands OSV-0003507

## Inspection ID: MON-0027545

## Date of inspection: 09/03/2022

**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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 3: Statement of purpose</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 3: Statement of purpose:<br>The statement of purpose has been re visited and the necessary amendments have been made to reflect full accuracy of information outlined and as required to ensure full compliance as part of the Re registration process.<br><br>The amendments made ensure full accuracy with regard to the following.<br>• The conditions of registration.<br>• The number of residents for whom the accommodation is to be provided.<br>• A description of the rooms in the designated center, including their size and primary function.</td></tr>
<tr><td>Regulation 28: Fire precautions</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 28: Fire precautions:<br>The concern raised and highlighted related to the error with the effective closing of the fire doors.<br><br>This concern was immediately addressed, Masterfire visited the center on 10/03/22 and repaired the fault on the fire doors. The Maintenance Manager from the HSE also visited to assess the situation, and it is confirmed that all fire doors throughout the premises are now in full working order.</td></tr>
<tr><td>Regulation 5: Individual assessment and personal plan</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:<br>Assessment of healthcare needs – There is active engagement through a Multidisciplinary team approach when assessing the healthcare needs of each individual resident. A monthly Medication review schedule is in place conducted through this team. Specialist</td></tr>
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| oversight is provided and includes guidance from senior Clinical staff ( Psychiatry ) , Psychology , Nursing with follow up support available through the Autism Practice Team.<br>Health Care Plans – The Location Manager and PIC will actively engage with members of the Autism Practice Team/health promotion team , to ensure that Health Action Plans are progressive, and regularly evaluated and reviewed through the schedule of Medication Reviews. |

| Regulation 6: Health care | Substantially Compliant |
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| Outline how you are going to come into compliance with Regulation 6: Health care:<br>The health of all residents is prioritized, and all staff remain very vigilant in monitoring any changes in an individuals presentation.<br>• Individual Capacity - Risk assessment and Active engagement with the Multidisciplinary team will guide the measures that can be implemented to support an individual in instances whereby an individual may refuse treatment, or not demonstrate the understanding of the implications of not receiving treatment. - 30/04/2022.<br>• Medical Advocacy support will be implemented to facilitate the individual and make every effort to reduce heightened anxiety related to receiving medical support/interventions or procedures. – 30/04/2022.<br>• Follow up care – will be prioritized within specified timescales, with clear health action plans documented, the Location Manager and the PIC will oversee the progression of this action. – 30/04/2022<br>A particular concern highlighted by our Inspector related to a particular individual – A further GP consultation has been facilitated, A Dexter scan and an MRI scan has also been organized. The Autism Practice Team are conducting an assessment and through Medical Advocacy support this resident will be facilitated to undertake any medical procedure that is advised to ensure his continued health and quality of life. 30/04/2022. |

| Regulation 7: Positive behavioural support | Substantially Compliant |
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| Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:<br>Restrictive Practice<br><br>• Hortlands House - Further to our Inspection on the 09/03/22 - The Safety feature in place at the top of a very steep staircase which is an identified fire exit, has been revisited by Gheel. This safety feature is now assessed as a restrictive practice, and will remain in place to ensure the safety of the residents at all times. This identified restrictive practice will now be notified in our quarterly returns.<br>• Phoenix House - The second Restrictive practice is located in Phoenix House which consists of a safety gate at the base of the staircase. This feature is to facilitate the safety and wellbeing of the resident, and is assessed as necessary in line with his changing needs.<br>In the interim this identified restrictive practice will be notified in our quarterly returns.<br>• The third restrictive practice which was identified by our Inspector ( Audio Monitor ) which was implemented to monitor falls post stroke for this resident . Following active engagement with a member of our Multidisciplinary team, this safety measure has now been reassessed, and no longer considered necessary. |

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| Positive behavioral support plans.<br><br>Residents health and well being is prioritized at all times.<br>Oversight by the multidisciplinary team addresses each individuals status, presentation and changing needs. This includes input from the Autism Practice Team, Nursing guidance, OT support, Psychology input and Senior Clinical oversight through regular medication reviews. A resident who currently engages in self injurious behavior will be further assessed by our Autism Practice Team, and a follow through on any practical aids/measures to reduce the intensity of the behavior will be fully implemented. This resident will also be facilitated through the positive application of Medical Advocacy support to reduce his heightened anxiety when receiving a medical procedure/intervention. |

| Regulation 8: Protection | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
Safeguarding – All staff have completed their Safeguarding Training, and fully understand/recognize varying forms of potential abuse. The designated Safeguarding Officer Team are in place across Gheel service, and fully available to staff at all times inclusive of evenings and weekends. There is a Senior Manager on call 24 hour service in place. Q Pulse ( internal safeguarding monitoring system ) is active and fully accessible to all staff. The PIC will monitor notifications in a robust manner  with each Location Manager. and will discuss all logged incidents and notify as required to both Hiqa and the Safeguarding Team.  The Autism Practice Team have oversight and review all Q Pulse notifications.

## 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 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Substantially Compliant | Yellow | 10/03/2022 |
| 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 | 07/04/2022 |
| Regulation 05(6)(a) | 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 be multidisciplinary. | Substantially Compliant | Yellow | 30/04/2022 |
| Regulation 05(6)(c) | The person in charge shall ensure that the personal plan is | Substantially Compliant | Yellow | 09/05/2022 |

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| | 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. | | | |
| 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 | 09/05/2022 |
| Regulation 06(2)(b) | The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated. | Substantially Compliant | Yellow | 19/04/2022 |
| Regulation 06(2)(c) | The person in charge shall ensure that the resident's right to refuse medical treatment shall be respected. Such refusal shall be documented and the matter brought to the attention of the resident's | Substantially Compliant | Yellow | 30/05/2022 |

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| | medical practitioner. | | | |
| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. | Substantially Compliant | Yellow | 30/04/2022 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 09/03/2022 |
| Regulation 08(3) | The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse. | Substantially Compliant | Yellow | 09/03/2022 |