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:	Meath Westmeath Centre 3
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	13 and 14 July 2023
Centre ID:	OSV-0004590
Fieldwork ID:	MON-0040838

About the designated centre

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

The designated centre comprises three locations, all within close proximity to the nearest small town. There is a three storey house in a housing estate which provides a full time residential service with a social care staff to up to five adults with medium support needs. The house consists of an open plan kitchen/dining room and sitting area, utility room, sitting room, five bedrooms (three are ensuite), two bathrooms. There is a garden to the rear of the house. There is also a detached bungalow in another housing estate which provides a full time residential service with, social care workers and support workers to up to five adults with medium to high dependency support needs. The house consists of five bedrooms (one with an en-suite), one main bathroom, sitting room, kitchen/dining area and utility room. There is garden to the rear of the house. Lastly there is a detached bungalow which provides a full time residential service with social care staff to one resident with medium to high support needs. The house consists of an open plan kitchen/dining/living area, a separate living area, utility room, two bedrooms and a bathroom. There is a garden to the rear of the property. The organisation provides services to both male and female residents over the age of 18. All houses have 24 hour staff support with sleepover staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Thursday 13 July 2023	10:30hrs to 17:30hrs	Julie Pryce	Lead
Friday 14 July 2023	11:00hrs to 15:30hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection conducted to ensure on-going compliance with the regulations, and in particular to follow up on actions agreed from an inspection conducted on 4 May 2022 in relation to infection prevention and control (IPC). In addition, the inspector reviewed compliance with regulations in relation to safeguarding following a series of notifications submitted to the Health Information and Quality Authority (HIQA) regarding the serious negative impact on some residents due to the behaviour of other residents.

This designated centre is made up of three locations which are, an individualised service for one resident, and two houses each of which currently accommodate four residents. The lived experience in each of these locations was very different and not all the findings outlined in this report apply to all three locations.

Over the two days of the inspection the inspector visited each of the three locations. The first location was a detached bungalow which is registered for five beds. There are currently four residents living in this house, all with high support needs in relation to personal care and support requirements with daily activities. The structure and layout of this premises is not adequate to meet the needs of these four residents, in particular in relation to a lack of storage and inadequate bathroom facilities, the impact of which will be further discussed later in this report.

The registration of this designated centre included five registered beds at this location, and at the feedback meeting at the conclusion of this inspection (at which the findings of the inspection are presented) the person participating in management informed the inspector that this issue had been recognised by the provider, and that there were no plans to admit a fifth resident.

However, even with this reduction, the inspector was concerned that the accommodation was not suitable to meet the needs of the four current residents. Whilst one of the bedrooms has an en-suite bathroom, it was too small to be used by the resident due to their limited mobility. This meant that the one main bathroom was used by all four residents, and the staff team, including the sleepover staff members.

On the day of the inspection there were three residents present at this house, and on arrival the inspector observed all three residents in the living room of the house. One of the residents who usually goes out to a day service, had chosen to stay at home that morning, and was occupied with table top activities and magazines, and appeared to be content and comfortable. This resident greeted the inspector with smiles, and showed her activities and drew the inspector's attention to a necklace she was wearing. Another resident was relaxing in a favourite chair, and was observed to approach staff with affection, and that staff communicated effectively with them.

However, the inspector was concerned that whilst staff were knowledgeable about the support needs of residents, and were making various efforts to ensure that their needs were met, the numbers of staff were not sufficient to ensure a meaningful day for each resident, and that the sensory needs of residents required additional input. These issues, again, are discussed in more detail later in this report,

Later that afternoon the inspector visited the second location which was a single storey detached house in a rural location and accommodates one resident availing of an individualised service. This home was beautifully decorated and furnished, and the resident had been involved in all the decisions in this regard. There were personal possessions and photographs throughout, and the living room contained a multitude of sensory items including scents, lighting and facilities to play music.

The resident who lived at this location was clearly proud of their home, and immediately got up to show the inspector around their home. They pointed out their favourite framed pictures and photographs of their family. The resident had a variety of activities available to them, and made their own decision each day as to their preferred way of spending the day.

On the second day of the inspection the inspector visited the third location which was a large and spacious home for four residents.

On arrival at this house the inspector observed one of the residents enjoying being in the kitchen/living area with staff, and the resident appeared to be content and comfortable at that time. They greeted the inspector with interest, agreed to show the inspector round their home, and invited the inspector into their bedroom which was spacious and nicely laid out with an en-suite bathroom for their sole use.

Another resident who was having a 'day off' from their day service was having a lie in, and later came into the kitchen and was again observed to very comfortable moving around their home and interacting with staff.

However, the behaviour of one of the residents was having a significantly negative impact on the other three residents, and these residents had all reported that they felt unsafe, and that they were afraid of their housemate. The implications of this are discussed in more detail throughout the report, however, the recorded conversations with residents included comments such as 'I am afraid of this person' or I am not coming out of my room because I am afraid of this person'. One resident had retired to their room after an incident and was heard vocalising to themselves and saying 'that resident hit me'. Whilst the recorded incidents did not include any physical injury, it was clear that residents did not feel safe in their own home.

It is of note that the resident whose behaviour was having a negative impact on others was also observed to have a very close and friendly relationship with another resident. They approached this person several times over the course of the inspection with smiles and hand held out, and were accepted by the other resident with affection. The two residents were seen to be holding hands, smiling and interacting fondly with each other. The person in charge and staff members also

explained that this was a close relationship.

Throughout the day it was clear that the rights of several of the residents in this house were not upheld both in terms of respecting the dignity and privacy of residents, and in ensuring that they could all feel safe.

The person in charge had undertaken training on assisted decision making, and discussed with the inspector the impact this would have, including a raised awareness of ensuring that the choices of residents were elicited. Whilst not all staff were yet in receipt of training in relation to upholding the rights of residents, this was recognised by the person in charge as being required in the near future.

Overall, there was a lack of oversight in the centre which meant that the inspector was not assured the care and support offered to residents was effectively monitored and this is corroborated by the non-compliance's with the regulations as outlined in the next two sections of this report.

Capacity and capability

There was a defined management structure, and all staff were aware of this structure and their reporting relationships. However, within this structure, there was insufficient evidence of effective oversight of this centre, or of appropriate and structured supervision of staff.

The various monitoring systems in place, such as the monthly audits and the annual review of the care and support of residents, did not provide effective oversight either in identifying issues of concern, or in addressing them.

The provider had failed to implement required actions agreed following the previous inspection of the designated centre in May 2023 relating to accommodations to be made to the structure of one of the houses which is unsuitable to meet the needs of residents.

There were serious negative effects on residents in another of the houses due to the behaviours of one of the residents which had not been managed, or the risk mitigated.

There was a consistent and competent staff team in place across the designated centre, although staffing numbers required review in one of the locations.

There was a complaints procedure in place however, recent complaints from residents had not been followed up in a timely manner.

Regulation 15: Staffing

All the staff members engaged by the inspector during the course of the inspection were knowledgeable about the care needs of residents, and could confidently describe their role in relation to various aspects of the support needs of residents.

However, the inspector was not satisfied that the numbers of staff in every house were at levels that ensured that all needs were met. In one of the locations, there were two staff members on duty each day. One of the residents had a day service but the other three residents required staff support to engage in activities. On the regular occasions where a staff member was engaged in a required activity outside the home, such as attending an appointment with a resident, taking one of the residents on an outing, or on a weekly occasion, where the staff member was doing the weekly shop for the house, other residents did not leave the house, and there was insufficient evidence to show that there were meaningful activities for residents on these occasions.

This issue had been brought to the attention of the provider at the previous inspection, and whilst it had been resolved by the provision of extra hours in the house, these hours were now discontinued since the number of residents reduced to four. However, the hours were required to ensure meaningful activities for all residents and thus the staffing issue remained unresolved.

A planned and actual roster was maintained as required by the regulations, however, where there were unexpected absences there was no effective contingency plan in place. On the night preceding the first day of the inspection, an agency staff member did not show up for duty. This staff member was to be the waking staff member that night, and as they were not replaced there was only the 'sleepover' staff member on duty that night. Whilst a review of the records showed that this was an extraordinary circumstance, the safety and wellbeing of residents was not assured on that occasion.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were all in receipt of mandatory training, although the training in relation to positive behaviour support was not adequate given the challenges of the behaviour of residents in one of the locations as discussed under regulation 7. However, additional training in relation to the healthcare needs of some of the residents had been provided.

Regular staff supervision conversations had not been held as required by the organisation's policy. This issue had been identified in the previous inspection, but had not been addressed. There was no clear schedule of staff supervisions, and

although the person in charge had begun to conduct the required conversations, this had only been completed with four staff members within the weeks prior to the inspection. In addition the inspector was not assured that the daily supervision of staff was adequate, in relation to the lack of a regular management presence in each location.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 23: Governance and management

Following the inspection of May 2022 the agreed actions in the response to the compliance plan included the requirement for the provider to submit a funding request to the HSE to ensure that adaptations were made to one of the locations to ensure the suitability of the premises to meet the needs of residents. The completion date for this action proposed by the provider and agreed by the chief inspector was September 2022.

However, the provider did not make the submission until April 2023, nine months after the required action was agreed, so that no progress had yet been made on this. This location therefore continues to be inadequate to meet the needs of residents, despite the number of residents having reduced from five to four.

Management and oversight of the designated centre was not adequate to ensure the safety and wellbeing of all residents. There had been a lack of management presence on-going for the months preceding the inspection. In the early months of the year the person in charge was covering various other duties within the organisation. Where there was an absence of the person in charge (PIC) for several weeks, there was insufficient evidence of oversight of the centre. The designated centre had been visited by the PIC of another centre on two occasions towards the end of this period, but there were no records to indicate any other occasions where there was a management presence in the centre during that time.

The required annual review of the care and support of residents had been completed, and was found to be a comprehensive document that had examined multiple aspects. However, where the action plan following this review had identified dates for completion, these were found to be, with the odd exception, to all be 28 July 2023.

Some of the required actions outlined had been completed, for example information relating to infection prevention and control (IPC) had been reorganised and made more readily available, and the communication section of personal plans had been reviewed. However, other actions had not been completed, for example the requirement to complete a risk assessment relating to a community risk in one location, and the identified need for staff to sign the minutes of team meetings to ensure that they were all in receipt of the information discussed at these meetings.

In addition, there was a monthly schedule of audits which were required to be undertaken in the designated centre. These audits were based on templates which outlined a list of questions, and which required a tick if compliant. There was no requirement to provide any evidence of compliance, and where some of the templates allowed for comment, this was rarely utilised, and where it was used, the exact same comment was inserted on each consecutive month. These audits were completed by staff members, but were not overseen by management. Across the suite of audits, no areas for improvement were identified, which is not consistent with the findings of this inspection. Thus it was clear that there was an over reliance on staff self-audit, and little evidence that this was an effective monitoring tool.

Judgment: Not compliant

Regulation 31: Notification of incidents

The required three day notifications had been submitted to HIQA as required, in particular all the incidents whereby the behaviour of a resident had a negative impact on others.

However, the quarterly notifications which are required to include any restrictions imposed on residents did not include two of the restrictive interventions in place.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place and records of any complaints were maintained which included information about any actions taken and referred to the satisfaction of the complainant.

However, there were three recent complaints which had been made by residents with the support of staff because they expressed that they were afraid of another resident due to the behaviour of this resident towards them. One of these complaints had been made two and a half weeks prior to the inspection, and another two weeks prior, but no meeting had yet been held with the residents to

discuss their complaints, despite the serious nature of their complaint.

Judgment: Not compliant

Quality and safety

There were personal plans in place for all residents, and these were available to residents in an accessible version, however improvements were required in some of the guidance relating to healthcare and personal care.

As previously mentioned, there was a different lived experience for residents in each of the three locations, and various areas of good practice in each. However, the rights of residents were not upheld in two of the locations for different reasons.

The premises in one of the locations was not adequate to meet their needs. Also in this location, the inspector was concerned about the daily choices of activities due to restrictions on staff time as mentioned in the previous section of this report. In addition, the right to dignity and respect were not upheld for one of the residents in relation to personal care.

The behaviours of concern in the other location was having a significantly negative impact on the lives of others, and this risk had not been managed or mitigated. There were further risks to residents which had been identified, but which were not monitored adequately. Therefore residents were not appropriately safeguarded.

Regulation 10: Communication

There was clear information in the personal plans for residents who did not communicate verbally, including a 'communication passport' and a supporting document which outlined the ways that residents communicated distress or pain.

The inspector observed both staff and the person in charge communicating effectively with residents in accordance with these documents. In addition staff had developed social stories for residents in various areas, for example there was a social story for one resident around a medical issue and the interventions that were required.

Judgment: Compliant

Regulation 13: General welfare and development

In two of the locations, there was evidence that residents were supported to have a meaningful life, and to be engaged in a variety of activities. They were clearly comfortable and content in their homes, and were observed by the inspector to be occupied appropriately, although as previously mentioned, the behaviour of concern had a negative impact on people's enjoyment of their home.

In the location where people had higher support needs, the inspector found that the staffing levels were frequently having an impact on the activities and occupation of residents. However, within these constraints staff members were involving residents in several different group activities. For example, they had all been involved in creating lovely pots of plants at the front of their home, and there were photographs in the personal plans in which they were all interested and engaged in this activity.

Where staff were available, it was clear that significant efforts had been made to ensure that activities offered to residents were appropriate to meet their needs, and were activities that they enjoyed. Some people enjoyed activities that could be provided within the constraints, such as listening to music, or playing with toys.

However, there was insufficient information to ensure oversight of activities in this house, as some of the records were either not completed, or were not available, and both staff and the person in charge discussed the constraints on at least some days, of only having two staff members on duty.

Judgment: Substantially compliant

Regulation 17: Premises

The premises in two of the three locations were appropriate to meet the needs of residents. There were adequate communal and personal areas in the shared house, and both locations had all the required facilities which were sufficient to meet the needs of all residents. There were gardens available for the use of residents, and these were furnished and had garden ornaments. Residents in these locations.

The other location was not adequate to meet the needs of the residents, despite the addition of an overhead hoist in one of the rooms. There were currently four residents, all of whom have mobility limitations. Each resident had their own bedroom, however, these bedrooms were all small single rooms, and as there was no available storage space in the house, all mobility aids including wheelchairs and walking aids were stored in these bedrooms, meaning that the space was then limited. There was a fifth bedroom which was currently vacant, and the inspector was informed that this will be used for storage from now on.

There was no area available in the house to create a sensory area for residents, and insufficient equipment or sensory items were to them in their rooms.

There is only one bathroom in this house which is shared by the four residents,

visitors and staff, including the sleepover staff. As discussed previously in this report, insufficient progress had been made towards ensuring that the required accommodations were made to the building.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was a risk register in each location in which, for the most part the identified risks were documented, and each of the entries referred to a risk assessment and management plan.

Various local risk assessments and management plans were in place, for example in relation to IPC, accidents and incidents and wheelchair safety. There were individual risk assessments in place for each resident which included some restrictive

However, in one of the locations there was a significant risk relating to anti-social behaviour in the community, and while the person in charge outlined some of the steps that had been taken, and informed the inspector that measures that were planned to mitigate this risk to residents, there was no documented risk assessment or control measures in place. For example, the requirement to ensure that the back door of the house was locked at all times was not in a document in order to guide staff practice, and there was no requirement on staff to record the adherence to this recommended practice.

There was, therefore, insufficient evidence that this significant risk was mitigated, or that it was being monitored, or that it had been escalated appropriately as a high risk.

Judgment: Not compliant

Regulation 27: Protection against infection

All three locations of the designated centre were clean and all the cleaning and maintenance issues identified in the previous inspection, which had focused on IPC, had been completed. In addition there was a detailed contingency now in place which included guidance in the event of an outbreak of an infectious disease.

However, it was agreed in the compliance plan following that inspection that the cleaning checklist would include items that had been found to require cleaning on that occasion, but this had not been completed. In addition, whilst the monthly suite of audits conducted by staff included an IPC audit, this was not overseen or monitored by management, and no other audit of IPC had been completed.

Whilst the houses were all visibly clean, the inspector observed in one of the houses that the mops were stored upside down in buckets outside the back door, one of them in water. This is not appropriate storage of mops in relation to IPC.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. All equipment had been maintained, appropriate checks had been completed. There were self-closing fire doors throughout the centre. However, on the first morning of the inspection the inspector observed a fire door propped open. Whilst the reason given was to air the room, the inspector checked the door and found that it would stay open without any obstruction.

Regular fire drills had been undertaken, and each resident had been involved in a fire drill. For the most part evacuations were completed in a timely manner, however on one occasion in May 2023, the drill had taken much longer than usual. There reason for this was documented, and related to the response of one of the residents'. However, there was no action plan identified to rectify this issue, or to mitigate the risk on future occasions.

Staff were knowledgeable about the steps they would take in the event of an emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was a detailed personal plan in place for each resident, based on an individual assessment of needs. There were sections in these personal plans relating to various areas of daily life, including both social and healthcare. There were accessible versions in the form of social stories of aspects of the care plans, and in addition there was a person centred plan in an accessible format.

Many sections of the personal plans included sufficient detail as to guide staff in the delivery of care and support, and although there were constraints due to staffing numbers in one of the locations, appropriate and meaningful activities had been identified for residents, and were provided wherever possible.

The inspector reviewed the intimate care plan for one of the residents, and found specific detail as to how staff should deliver care in this regard.

However, some of the healthcare plans did not include sufficient information. For

example, a care plan in relation to epilepsy included a goal that 'staff to have up-to-date training' which is not providing any guidance. There was a drop down menu from which 'full physical assistance required' had been chosen, but no further detail. A review of the related 'as required' medication protocol for the prescribed rescue medication for this resident was detailed, and described the circumstances under which the medication should be administered, but the re ws no guidance as to the care that should be offered in the event of a seizure occurring, or following a seizure.

Judgment: Compliant

Regulation 6: Health care

There was evidence of a swift response to the presentation of residents in relation to changing healthcare needs. For example, where staff had observed that the urine output of a resident was significantly lower than normal, and that their presentation differed one morning, immediate action was taken, and the resident received appropriate healthcare that day.

Residents had access to the appropriate members of the multi-disciplinary team, for example one of the residents had a home visit from their physiotherapist each week.

Staff were familiar with the healthcare needs of residents and could describe the interventions that were required. Some of the documented healthcare plans in the personal plans required further detail, as mentioned under regulation 5.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents in one of the locations were not safeguarded from the impact of behaviours of concern of one of the residents with whom they shared their home. They were vulnerable to repeated incidents of behaviours of concern which had a serious impact on their wellbeing. There were several occasions where residents had expressed their feelings of being unsafe.

Whilst these incidents had been recorded and reported appropriately, none of the measures currently in place were ensuring their safety. Whilst the impact of the behaviour of this particular resident had been recognised by the organisation as having a negative impact on the quality of life for others, and there had been reviews by both the mental health team and the behaviour support team, there was no clear guidance to staff as to the steps they should take in the event of an escalation of behaviours. There was a flow chart in place with some interventions

outlined, but the description of the behaviour that required intervention was vague, for example it referred to the resident's' inability to self-regulate, but did not specifically identify the behaviour. The intervention appeared to relate to the self-injurious behaviour of the resident, but not to the behaviours that were having such a significant impact on others.

There was a recording chart template in place which staff completed after each incident of challenging behaviour, but one of the questions required staff to identify which of the steps in the reactive strategy they had implemented. This section was not completed on the occasions reviewed by the inspector, and in fact there was no reactive strategy for them to refer to.

There had been on-site training with staff in relation to breakaway techniques in the event of physical intervention being required to ensure their safety in the event of identified behaviours of concern. However, there was no evidence of any other training in relation to the management of behaviours of concern as required by the regulations.

In addition, where there were restrictive interventions in place, not all had been recognised as being restrictive, so that the appropriate documentation and oversight was not in place. There was a sensory bed monitor in relation to epilepsy and a sensor at the top of the stairs to alert staff of the movement of the resident whose room was on the top floor of the house. Whilst the person in charge gave a clear rationale for these interventions, they had not been recorded appropriately and were not included in the oversight of restrictive interventions in the centre.

Judgment: Not compliant

Regulation 8: Protection

As outlined under regulation 7, residents in one of the locations were not safeguarded from the impact of behaviours of concern of another resident with whom they shared their home. They were vulnerable to repeated incidents of behaviours of concern which had a serious impact on their wellbeing. There were several occasions where residents had expressed their feelings of being unsafe.

Incidents had been recorded in detail and included occasions both verbal and physical abuse of residents by the resident engaging in behaviours of concern. There had been 13 such recorded incidents between February 2023 and the day of the inspection.

While the person in charge had prepared the required safeguarding plans and submitted them, as required, no solutions had been reached, and residents continued to be unsafe.

The inspector reviewed the management of residents' personal spending money in one of the locations. Everyday spending was well managed in that each transaction

was recorded and a receipt for the purchase maintained. Each residents' record and balance was checked by two staff each day. However, each resident had an in-house receipt for €10 included in the recent account, with no explanation as to the nature of the purchase, other than the comment 'gift' on one of the receipts. This did not provide adequate oversight of this sending. Queries were made to staff members not on duty that day, and there was a rational explanation for this expenditure, however the method of documenting such purchases was not adequate. The balance of one of the resident's moneys against the record checked by the inspector was correct.

In addition, one of the resident's had a 'swirl' card, which was mostly used for monthly items such and Netflix. It was unclear as to whether the balance on this card was currently accurate, as up-to-date records were not available.

Judgment: Not compliant

Regulation 9: Residents' rights

There was inconsistency across the three locations of this designated centre in relation to the upholding of the rights of residents.

In the location where the resident lived alone and had an individualised service, this resident had support with having their rights upheld, and was observed by the inspector to have a good quality of life, and to be making their own decisions. The person in charge and staff described a significant improvement in the presentation of the resident since they moved to this house.

However, there were issues in both the other locations where the rights of residents were not supported.

In the location where residents had high support needs, their rights to have a meaningful life and to choose activities was not always respected. Furthermore the inspector was concerned about the right to privacy and dignity for one of the residents in particular. This person had significant mobility needs, and required transfer from their bedroom to the bathroom down the corridor. This was described by staff as being managed by undressing the resident, placing them in the hoist with a towel over them and wheeling them down the corridor in the hoist. A review of the care plan around this activity found that this was the documented guidance in place. This practice did not respect the dignity of the resident, and various other ways of managing this transfer with dignity had not been explored.

In this location there was the additional concern about the provision of meaningful activities for all residents. In addition to the constraints brought about by staffing numbers as mentioned earlier in the report, there was very little in place in relation to the sensory needs of residents. One of the residents had a lava light in their room, but this ws the only sensory item observed by the inspector.

The behaviours of concern of a resident in the other location was having such a serious effect on other residents that they had said that they felt unsafe in their home. Insufficient measures were in place to ensure their safety, and while a meeting had been planned for the Monday following the inspection, these behaviours had been ongoing since February 2023, and no effective interventions were in place.

A compatibility assessment had been conducted in February 2023 by the positive behaviour support team in this location, however, the focus of this assessment had actually been the behaviour of another resident, which whilst annoying to others, did not pose a significant risk to their safety.

In all three locations there was clear evidence of information being provided to residents, and an emphasis on communication. For example, all efforts were made to ensure residents' understanding prior to any medical procedure, and to explain interventions to them. There was documented information about the best ways in which to communicate with people to maximise their understanding.

Overall, while there were significant shortfalls in the support of residents' rights, all staff members were observed to interact with residents in a caring and respectful way, and it was clear form the response of residents that there were familiar and comfortable relationships with them.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Meath Westmeath Centre 3 OSV-0004590

Inspection ID: MON-0040838

Date of inspection: 13/07/20223 and 14/07/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
It has been agreed by PPIM and the Registered Provider to reduce the capacity of the Designated Centre to 8. This will reduce the occupancy of House 2 to 3 residents. The transition, consultation and planning required has started with the resident proposed to move to another designated centre (that has been identified to better meet the residents assessed needs) and their representatives. This transition will be supported in line with the residents own pace. Once this transition is complete the staffing compliment will remain the same (2 staff) to ensure supports to meet the assessed needs of the remaining 3 residents.
This will mean that on weekdays while one resident is attending their day services, 2 staff will be on duty to support the remaining 2 residents in meaningful activities either within their home or local community. Where additional support is required for appointments, the PIC will plan the staff roster to ensure the sufficient staff are in place. For the weekly house shopping, this is also planned and scheduled to take place at times when one resident is at the day service and when there is an inhouse activity planned for the other 2 residents that is adequately supported by one staff – i.e. a sensory integration programme.
In the interim period until this transition is complete and the capacity reduced to 3, the interim measure of the additional 4 hours supports per day each day over the 7 days / week that was introduced on the 15th August, 2023 will remain in place until transition of one resident to new designated centre.

The PIC will ensure all rosters with relief/agency staff bookings are reviewed before the end of each working day to ensure staff are available and will present for work. On exceptional occasions where staff do not show up for out of hours shifts, the out of hours manager on-call will cover the shift.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Comprehensive Positive Behaviour Support Training for staff team of House 1 has been delivered on the 31/08/2023. This was facilitated by Senior Clinical Psychologist and their team. Training is aligned to the resident's Safety and Support Plan. This training will clearly define what the resident's behaviours of concerns are and how they present. The training will also set out the proactive and reactive positive behaviour support strategies specific to this resident's needs.

Clinical Psychologist and their team will provide mentorship to the PIC and staff in the implementation of this Safety & Support Plan for the resident.

The staff, MDT and Management support team of the resident requiring the above behavioral support have identified:

A. The benefits of an Individualised Intensive Assessment and Support Service for the resident at this time.
B. That this Assessment will be best delivered in another designated period for 6-8 week period starting 08/09/2023.

These supports will be overseen by the Clinical Psychologist, Area Director and PIC. The training support and guidance will be delivered to the staff team by the Clinical Psychologist and Behaviour Support Therapist.

The PIC now works from the designated centre 4 days per week to ensure implementation of the compliance plan, review all audits and conduct spot checks.
The PPIM visits the designated centre on a weekly basis to ensure implementation of compliance plan and to conduct spot checks.
The PPIM meets with the PIC on a weekly basis to review and record progress in relation to the compliance plan and its implementation.

The PIC has an annual supervision schedule in place and supervision and support meetings will be completed with all staff by 08/09/2023. The completed supervision schedule will be signed off and submitted to the PPIM on the 9/9/23 and subsequently reviewed Quarterly by the PPIM.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
On the 30/08/23 The CEO and Regional Director met with HSE Management to review the current Non-Compliances within the Designated Centre and also the wider funding approval system. In relation to the non-compliance re Premises, it was agreed a more prudent option to reduce the Designated Centre's Capacity to 8 residents (House 2 occupancy will decrease from 5 Residents to 3 Residents) would provide better outcomes as opposed to making adaptations to House 2. The Provider is currently in the process of preparing an Application To Variation of Conditions of the designated centre to decrease the capacity from 10 Residents to 8 Residents. This reduction in Resident numbers will be from 5 Residents to 3 Residents in House 2. This application will be submitted upon the completion of one resident's transition from the Designated Centre to a New Registered Designated Centre.
Funding has been approved for the reconfiguration of the ensuite bedroom in House 2 to be converted to a new standalone bathroom (bathroom 2), fully equipped to meet the needs of the residents. The resident currently residing in the ensuite bedroom will be consulted and supported to transition to another bedroom vacated by the resident transferring to the new Designated Centre.

Funding has also been approved for the installation of the overhead tracking hoist in Bathroom 1 (existing) to meet the assessed needs of a resident.

The PIC works from the designated centre 4 days per week to ensure implementation of the compliance plan, review all audits and conduct spot checks.
The PPIM visits the designated centre on a weekly basis to ensure implementation of compliance plan and to conduct spot checks.
The PPIM meets with the PIC on a weekly basis to review compliance plan and record progress in relation to the compliance plan and its implementation.

The PPIM and PIC have reviewed Annual Report 2022 and agreed to ensure more reasonable timeframes for actions following completion of Annual Report for 2023 and going forward. This has been agreed and submitted to the Regional Director to ensure greater oversight.

A Risk Assessment has been completed by the PIC on the identified anti-social behaviour and signed off by the Area Director and staff team.
The installation of CCTV external to the designated centre as a deterrent to anti-social behaviour has been approved for funding and awaiting installation.

All Team Meetings and Action Plans have been signed off by team members and the themes reviewed through Supervision with the PIC and PPIM.
A schedule of staff team meetings has been distributed to all locations for the remainder of 2023.

All location specific audits have been signed off by the PIC. The PPIM has (15/08/23) engaged with the Quality, Safety and Risk Manager regarding the review and redesign of the current Audit Documentation.
Directive/Guidance on the accurate completion of location specific audits (including visual and physical check) has been distributed to all staff teams by PIC on 14/08/2023 and will

be an agenda item for continual discussion and review by PIC going forward. These will also be reviewed for learning and quality improvement through the supervision meetings with PIC and PPIM.

Visitors book and spot checks of audits and records are completed by the PIC and PPIM at each visit at the Designated Centre.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All restrictive practices in operation in the designated centre have been notified on Portal on Quarter 2 notifications by the PIC.
All restrictive practices will be continuously reviewed by the clinical team and Restrictive Practice Review Committee.
The PIC Monthly Report has been updated to include a section for each PIC to review any new practices, interventions or aids for any resident that would constitute a restrictive practice. This has come into effect since 01/08/23.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
PIC has met with both residents who raised the complaints referred to in the report.

PIC met with Resident 1 on 19/07/2023 to hear details of the complaint. The PIC agreed to meet the residents weekly to discuss any issues that were causing distress to them in the house. The PIC also agreed to develop a specific forum for all residents to discuss their experiences of living in House 1 and what can be done to improve it. The resident was satisfied with the assurances they were given at this meeting.

PIC met with Resident 2 on 20/07/2023, to hear details of the complaint. The PIC agreed to meet the residents weekly to discuss any issues that were causing distress to them in the house. The PIC also agreed to develop a specific forum for all residents to discuss their experiences of living in House 1 and what can be done to improve it. The resident was satisfied with the assurances they were given at this meeting.

PIC has scheduled a specific residents meeting for 16/09/2023 to meet with the residents in House 1 to discuss using the complaints system and how we can improve residents

experience of living in this house. This forum is put in place to take place Monthly for the residents.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The Behaviour Support Plan has been developed by Behaviour Support Therapist, PIC and staff team. This was distributed to staff team on 25/07/2023.
The Clinical Psychologist will provide on-site mentorship to PIC and staff team in implementation of Safety & Support Plan for resident.

The Comprehensive Positive Behaviour Support Training for staff team of House 1 has been delivered on the 31/08/2023. This was facilitated by Senior Clinical Psychologist and their team. Training is aligned to the resident's Safety and Support Plan. This training will clearly define what the resident's behaviours of concerns are and how they present. The training will also set out the proactive and reactive positive behaviour support strategies specific to this resident's needs.

Clinical Psychologist and their team will provide mentorship to the PIC and staff in the implementation of this Safety & Support Plan for the resident.

The staff, MDT and Management support team of the resident requiring the above behavioral support have identified:

C. The benefits of an Individualised Intensive Assessment and Support Service for this resident at this time.
D. That this Assessment will be best delivered in another designated period for 6–8-week period starting 08/09/2023.

These supports will be overseen by the Clinical Psychologist, Area Director and PIC. The training support and guidance will be delivered to the staff team by the Clinical Psychologist and Behaviour Support Therapist.

Staffing levels- It has been agreed by PPIM and Registered Provider to reduce the capacity of the designated centre to 8. This will reduce the occupancy of House 2 to 3 residents in House 2. The staffing levels will remain the same to ensure supports to meet the assessed needs of all residents.
Transition consultation and planning has begun with the resident proposed to move and their representatives. In the interim period:
Immediate Interim measure of 4 hours additional support over 7 days implemented 15th August, 2023.

Weekly activities schedule in place for residents in House 2, this is reviewed on weekly basis and signed off by PIC along with review by PPIM as part oversight of implementation of the compliance plan.
Community Mapping project to be completed by 30/09/2023 to allow residents choose local amenities, activities, social opportunities, education or skills training in line with personal will and preference.

All resident activities are now recorded daily as part of resident's daily progress report including level of engagement and outcomes for residents.
House 2 put forward as a pilot site for roll out of new electronic person-centered planning module which with guidance/support to all keyworkers.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
On the 30/08/23 The CEO and Regional Director met with HSE Management to review the current Non-Compliances within the Designated Centre, particularly in relation to the non-compliance re Premises, it was agreed a more prudent option to reduce the Designated Centre's Capacity to 8 residents (House 2 occupancy will decrease from 5 Residents to 3 Residents) would provide better outcomes as opposed to making adaptations to House 2. The Provider is currently in the process of preparing an Application To Variation of Conditions of the designated centre to decrease the capacity from 10 Residents to 8 Residents. This reduction in Resident numbers will be from 5 Residents to 3 Residents in House 2. This application will be submitted upon the completion of one resident's transition from the Designated Centre to a New Registered Designated Centre.
Funding has been approved for the reconfiguration of the ensuite bedroom in House 2 to be converted to a new standalone second bathroom (bathroom 2), fully equipped to meet the needs of the residents. The resident currently residing in the ensuite bedroom will be consulted and supported to transition to another bedroom vacated by the resident transferring to the new Designated Centre.

Funding has been approved for installation of overhead tracking hoist in Bathroom 1 (existing) to meet the assessed needs of a resident- awaiting installation.

Spare room in House 2 is now converted to storage space for location and in use since 18/08/2023.

Sensory review for 2 residents completed by Occupational Therapist on 28/07/2023. Report and recommendations distributed to PIC and staff team for implementation on 02/08/2023.

Transition of 1 resident to more suitable premises/designated centre to meet assessed sensory needs in external and internal environments.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A Risk Assessment on community risk of anti-social behaviour has been developed and implemented. A record of adherence to the control measures in place in this location.
Installation of CCTV external to the designated centre as a deterrent to anti-social behaviour- funding approved, awaiting installation.
These will provide an additional measure of security for residents and staff.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Updated Cleaning Checklists, including cleaning of bathroom vent now implemented in designated centre since 01/08/2023.

Six Monthly IPC audit completed by PIC on 08/08/2023 as per IPC Policy & Procedure.

All mops and mop buckets are now stored in outside storage area. Directive on appropriate storage of mop and bucket issued to all staff in designated centre on 14/08/2023.

PPIM will review via supervision and monthly report review with PIC.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Safety- door stopper removed from designated centre. Directive on safe and appropriate operation of fire doors delivered to all staff in designated centre on 14/08/2023 and discussed at August 2023 staff team meeting.

Issues arising with Fire Drill conducted in May 2023- on 14/08/2023 keyworker met with resident who had recorded increased evacuation time to review the evacuation and discuss need to evacuate in a timely manner to ensure safety, any additional support needs will be provided to resident going forward. All subsequent evacuations reviewed by PIC to ensure evacuations are happening within a safe timescale. Any issues arising will be escalated to PIC or PPIM going forward as they arise and also via PIC Monthly Report

Action Plan from May 2023 Fire Evacuation Drill updated and signed off by PIC.

Oversight from the PPIM via Monthly Reports and Supervision.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Health Care Plans – Epilepsy Care Plan has been reviewed and updated to ensure all the necessary information is included. This has reduced any potential risk and ensures a better standard of support to the resident to manage their epilepsy.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A New PBS Plan (Safety & Support Plan) has been developed by Behaviour Support Therapist, PIC and Staff team- distributed to staff team on 26/07/2023. This plan will be reviewed by the above on 05/09/2023.

Comprehensive Positive Behaviour Support training scheduled to be delivered to staff team on 31/08/2023. This has been developed and delivered by Senior Clinical Psychologist.
This training will be closely aligned to the resident's Safety & Support Plan and location specific.

MDT Meeting convened on 17/07/2023 to review resident and all supports provided to this date, comprehensive action plan developed of additional supports required by resident at this time, follow up meeting convened 22/08/2023.

Individualised Intensive Assessment and Support service will be provided to resident in

another designated centre for a 6-8 week period starting 11/09/2023.
If clinical team decide a further extension is required at end of 8 week period to ensure better outcomes for the resident a meeting will be convened with Clinical Psychologist, Regional Director and Area Director to approve this in consultation with resident.

This support will be overseen by the Clinical Psychologist, Area Director, P.I.C. Training support and guidance will be delivered to staff team by Clinical Psychologist and Behaviour Support Therapist.
The staff support team for this period will be comprised of members of usual staff team, nursing support, with Behaviour Support Therapist on site for 2 days per week and Clinical Psychologist on site for 1 day per week.
Assessment will comprise of a holistic overview of resident's health and welling, including physical health, nutrition, positive behaviour support, mental health support through Mental Health (intellectual disabilities) services, sensory integration supports (OT)

During this period there will be a weekly planning and review meeting attended by Clinical Psychologist, Area Director, PIC, Behaviour Therapist and nursing support.

Residents' existing friendships will be supported throughout this assessment and support period through visits, phone calls and video calls.

All restrictive practices in operation in the designated centre have been notified on Portal on Quarter 2 notifications.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
PIC met with the Designated Safeguarding Officer on 08/08/2023 to review all Safeguarding Plans implemented in the designated centre.

The Designated Safeguarding Officer has met with the staff team on 31/08/2023 to review all Safeguarding Plans and strategies.
Designated Safeguarding Officer met with PIC 08/08/23 to review all incidents and Safeguarding Plans. PPIM (Area Director) and PIC met at monthly review meeting to review same. Subsequently the CEO, Area Director, Regional Director and Senior Psychologist met 24/08/23 to explore and put forward solutions. Agreement made to utilize a vacant Designated Centre to provide the Resident causing concern/requiring intense behavioral supports for a period of 6 to 8 weeks.

Individualised Intensive Assessment and Support service will be provided to this resident in another designated centre for a 6–8-week period starting 08/09/2023. These supports will be overseen by Clinical Psychologist, Area Director, PIC. Training, support and guidance will be delivered to the staff team by the Clinical Psychologist and Behaviour

Support Therapist.

If clinical team deem a further extension is required at end of 8-week period to ensure better outcomes for the resident a meeting will be convened with Clinical Psychologist, Regional Director and Area Director to approve this in consultation with resident.

Money management – A directive was issued to all staff in the designated centre on appropriate receipting of all resident's monies in line with the Organisations Guidance Policy on the Protection of Services Users Personal Possessions Properties and Finances.

Swirl Card- The resident who has Swirl Debit Card now has access to account balance through use of App on phone. This is checked daily and signed off daily by 2 staff. PIC has a written protocol and staff sign off on same.

There is an ongoing compatibility review of all residents in House 1. There is also an ongoing transition plan for one other resident to relocate back to a designated centre closer to their family home.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Resident's Intimate Care Plan on has been updated to reflect strict adherence to residents' dignity and respect with review to transfers completed by Occupational Therapist and Physiotherapist.
Team Meeting addressed the impact on the resident dignity with poor practices with intimate care support. A staff reflection piece also took place as part of team meeting.
CEO, Regional Director, Area Director and Senior Psychologist met with staff team on 28/08/23 to discuss appropriate practices on the deliver of Intimate and Personal Care in line with The Muiriosa Foundations Vision and Mission and Policy on Intimate and Personal Care. This meeting also explored the leadership responsibilities of all staff to identify and eliminate any practices that could in any way have an impact on the residents' dignity.
At the monthly meeting, an agenda item on care practice review has also been established.

Overhead tracking hoist system bathroom- funding approved for installation of this, awaiting installation.

In relation to the residents rights to be in a safe environment, an Individualised Intensive Assessment and Support service will be provided to the resident causing concern/requiring intensive behavioral supports in another designated period for 6-8 week period starting 08/09/2023. These supports will be overseen by the Clinical Psychologist, Area Director, P.I.C. Training support and guidance will be delivered to staff team by Clinical Psychologist and Behaviour Support Therapist.

This will allow time for residents to receive necessary supports and also time to alleviate the ongoing safeguarding concerns for the remaining 3 residents in the location.
PIC has met with Designated Safeguarding Officer on 08/08/2023 to review Safeguarding Plans to ensure better outcomes for all residents.

On the 30/08/23 The CEO and Regional Director met with HSE Management to review the current Non-Compliances within the Designated Centre, particularly in relation to the non-compliance re Premises, it was agreed a more prudent option to reduce the Designated Centre's Capacity to 8 residents (House 2 occupancy will decrease from 5 Residents to 3 Residents) would provide better outcomes as opposed to making adaptations to House 2. The Provider is currently in the process of preparing an Application To Variation of Conditions of the designated centre to decrease the capacity from 10 Residents to 8 Residents. This reduction in Resident numbers will be from 5 Residents to 3 Residents in House 2. This application will be submitted upon the completion of one resident's transition from the Designated Centre to a New Registered Designated Centre.
Funding has been approved for the reconfiguration of the ensuite bedroom in House 2 to be converted to a new standalone second bathroom (bathroom 2), fully equipped to meet the needs of the residents. The resident currently residing in the ensuite bedroom will be consulted and supported to transition to another bedroom vacated by the resident transferring to the new Designated Centre.

Staffing levels-
Interim measure of 4 hours additional support over 7 days implemented 15/08/2023.

Sensory review for 2 residents completed by Occupational Therapist on 28/07/2023. Report and recommendations distributed to PIC and staff team for implementation on 02/08/2023.

Weekly activities schedule in place for residents in House 2, this is reviewed on weekly basis and signed off by PIC along with review by PPIM as part oversight of implementation of the compliance plan.
Community Mapping project to be completed by 30/09/2023 to allow residents choose local amenities, activities, social opportunities, education or skills training in line with their personal will and preference.

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)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/09/2023
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/12/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately	Not Compliant	Orange	11/09/2023

	supervised.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2023
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	31/12/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	15/08/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are	Substantially Compliant	Yellow	15/08/2023

	protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	27/07/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	15/08/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or	Substantially Compliant	Yellow	14/08/2023

	environmental restraint was used.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	20/07/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/07/2023
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	01/09/2023
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	08/12/2023
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates	Not Compliant	Orange	08/12/2023

	intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2023
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/09/2023
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.	Not Compliant	Orange	31/07/2023