Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	The Elms
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Announced
Date of inspection:	29 July 2024
Centre ID:	OSV-0004877
Fieldwork ID:	MON-0035768

About the designated centre

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

In this centre, a residential service is provided for a maximum of four residents over the age of 18 years. The service provided responds to individual requirements with some residents availing of a less than full-time service. The centre is comprised of two separate premises located in the suburbs of the main town. Two residents live in each of these houses. One house has an apartment attached where one resident resides. Each premises provides residents with access to their own bedroom, some en-suite facilities, shared bathrooms, sitting rooms, kitchen, dining areas, front and rear gardens. The model of care is social and staff are on duty both day and night to support the residents who live in this service. Management and oversight of the day to day operation of the service is undertaken by the person in charge supported by social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Monday 29 July 2024	10:00hrs to 17:45hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to monitor the provider's level of compliance with the regulations. The provider had submitted applications to both vary the current conditions of registration and to renew the registration of this centre. The Chief Inspector of Social Services had, in 2021, registered this centre with a condition that the provider address the regulatory non-compliance in the centre. The inspector found that the provider had made good progress in this regard including securing additional resources. The provider continued to improve the appropriateness, quality and safety of the service provided to residents. Plans such as the transition of one resident to accommodation better suited to the needs were nearing completion. Efforts were in progress to improve resident autonomy and independence. However, the inspector found that while there was, on discussion, absolute clarity on residents' needs, supports and plans, that clarity was not always reflected in records seen. This meant that there was an absence of assurance as to how the provider effectively monitored and assured itself that day-to-day practice was in line with the plans and, was achieving the desired outcome.

Currently this designated centre is comprised of two houses located a short distance from each other. Both houses are domestic style two-storey properties in residential areas and two residents reside in each house. On this inspection the inspector focussed on the care and support provided in one of these houses. The inspector visited the second house in the evening. Previous inspections have focussed on that second house. The inspector had the opportunity to meet with all four residents and the staff members on duty in both houses. The inspection was facilitated by the person in charge.

On arrival at the first house the inspector noted the local county flag was still flying celebrating the recent win in the All-Ireland Hurling final. The house looked well, the garden was tended to and a new front-door had been installed. The person in charge was aware of the recent increased incidence of COVID-19 and established that the inspector was well prior to the inspector entering the house. The residents were not at home but were due to return later in the morning.

Prior to the residents returning to the house the inspector discussed with the person in charge matters including the governance and management of the overall centre, the plan to transition one resident to a house better suited to their needs, staffing arrangements and, the daily routines, care and support needs of all four residents. The person in charge could clearly articulate to the inspector how they planned, managed and monitored the centre. It was evident that the person in charge maintained an active presence in the house. There was evidence of good governance. For example, the review of incidents and restrictive practices and the communication between the person in charge, their line manager and the wider multi-disciplinary team (MDT). However, when the inspector commenced the review of records the inspector found that the plans for enhancing residents' quality of life

were not as clearly represented in records such as the daily narrative notes and monitoring tools maintained by staff. There was some evidence to support a lack of capacity in the management arrangements to ensure consistent oversight and general administration.

When the residents arrived back to the house they smiled and waved at the inspector as they got out of the car. Individually, both residents came to greet the inspector, shook the inspectors hand and welcomed the inspector to their home. Both residents had assessed verbal communication needs but they greeted the inspector with confidence. Both residents looked well and were in great form. The inspector gave the residents some time to relax and the person in charge asked the residents if they would like the show the inspector their bedrooms. Both residents did this willingly and agreed amongst themselves who would go first. Both residents showed the inspector items and photographs that were important to them such as of home and family, peers, events and activities that were important to them. One resident had and shared with the inspector a number of photographs representing their pathway so far through life. Many of the photographs shared by both residents represented the broad range of activities and interests that they had. This included sports such as hockey, golf, swimming, trips to the cinema, music events and enjoying socialising in the local and wider community. One resident was planning for their upcoming birthday and was planning to have a barbecue in the garden for friends and family. One resident on showing the inspector his wardrobe said that he selected and bought his own clothes. One resident loved art, had some completed works displayed in his room and was going to participate in the street art element of the advocacy conference later in the year.

The residents came and went with staff. For example, they left to do the weekly grocery shop and on their return they carefully put away the items bought. They left again to buy some items for the planned birthday celebration.

The provider had and was taking action to respect the longstanding relationship between these residents while also supporting the residents to develop independence, exercise choice and control and, to make different life choices. The provider was working through the findings and recommendations of an external review commissioned in response to previous HIQA inspection findings. Staff spoken with said that the residents lived well together on many levels but there was increased staff awareness now of their differences and their individuality. The person in charge had engaged the services of an independent advocate to support three residents in different ways such as advocacy support in seeking the resources needed to extend the scope of their service.

All four residents had contact with home and family as appropriate to their individual circumstances and funding arrangements. For example, two residents returned home to family every weekend. Family members were free to visit the centre. The person in charge had invited family and residents to provide feedback to inform the 2023 annual review. Three of four families had responded and described the service provided as excellent. Residents said they felt safe, liked their staff teams and named specific staff that they would talk to if they had a concern or worry. Staff had also supported the residents to complete a questionnaire for HIQA. This feedback

was also positive with residents reporting that they liked living in the centre, could make choices and felt safe.

When the inspector visited the second house both residents were present with three supporting staff members. These staffing levels represented the additional staffing put in place by the provider since the last HIQA inspection. Staff were aware of the pending transition and confirmed that some staff team members were to transition with the resident. This resident was in the garden to the rear of the house. The inspector met with the resident and their supporting staff member. The resident just looked gently and held brief eye contact with the inspector. The staff member confirmed that with the increased staffing levels the resident had the opportunity to be out and about in the community each day.

The other resident was relaxing upstairs. The inspector knocked on the door and was invited in by the resident. The resident said that they were well. The resident knew that their peer would be moving out shortly and that they might have a new housemate. The resident did not express any particular opinion on these changes. The resident did discuss one matter that was troubling them. This matter had been discussed during the inspection with the person in charge. The concerns expressed by the resident were brought to the attention of the person in charge and their line manager during verbal feedback of these inspection findings.

In summary, the provider has brought about much improvement in this service to enhance the appropriateness, quality and safety of the service. Further work was underway to promote the level of independence, choice and freedom that residents had to direct their own lives including the objective of living semi-independently. However, improvement was needed in the recording of how these plans were progressed including how residents were responding and engaging with the plans.

The next two sections of this report will discuss the governance and management arrangements in place and how these assured the quality and safety of the service.

Capacity and capability

The provider continued to improve the governance and management of this centre. The provider had continued to seek and had received the resources needed to improve the quality and safety of this service. The provider was open to changes that needed to occur in how residents were supported. However, while the provider was on a day-day-basis collating information about the care and support provided in the centre, some records seen lacked detail and, it was not consistently clear how some information was used so as to effectively monitor the service. There was also, based on these inspection findings, evidence of a lack of capacity within the local systems of management to provide consistent oversight and monitoring.

Day-to-day management and oversight of the service was delegated to the person in charge. It was evident from speaking with the person in charge and from records seen that the person in charge was consistently engaged in the planning, management and oversight of the centre. The person in charge was supported by social care workers who had delegated duties and responsibilities.

For example, a social care worker told the inspector that they had received training in the completion of staff supervisions prior to undertaking this duty. The social care worker said there was good opportunity for staff to avail of education and training. The social care workers completed supervisions with the frontline staff team. The person in charge completed supervisions with the social care workers and staff who were more recently recruited. The inspector was advised that these supervisions were all up-to-date.

The staff training matrix included a record of the training completed by all staff members working in the centre including staff who worked on a relief basis. Training such as in safeguarding, fire safety and responding to behaviour of concern was either complete or scheduled.

The person in charge endeavoured to convene regular staff meetings. However, only the person in charge and the social care worker had attended the April 2024 meeting and, there were no records available for inspection of who attended and what was discussed at the May and June staff meetings.

This was of some concern given the staffing arrangements in the service and the role of the staff meetings in communicating with staff and keeping staff appraised of any changes in the care and support needs of residents. The inspector was advised that five of the seven staff employed in one house worked across different areas. Based on these inspection findings the inspector was not robustly assured how the provider ensured these arrangements ensured consistency and continuity of care and support.

The provider had formal quality assurance systems such as the annual review and the quality and safety reviews required to be completed at least on a six-monthly basis. These reviews monitored the progression of the previous quality improvement plans and reported satisfactory progress.

The person in charge maintained good oversight of any incidents that had occurred and how any risks arising were controlled. However, records and monitoring tools such as in relation to behaviour that had the potential to upset peers did not, based on these inspection findings, provide robust information that was sufficient to inform monitoring and oversight

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a complete and valid application seeking renewal of the

registration of this designated centre.

Judgment: Compliant

Registration Regulation 8 (1)

The provider submitted a complete and valid application seeking variations to the conditions of registration of this designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time and had the experience, skills and experience needed for the role. The person in charge could clearly describe to the inspector how they planned, managed and monitored the designated centre. It was evident from records seen such as records of incidents that occurred, that the person in charge was present in the centre and actively engaged in the management and oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had continued to seek additional resources from their funding body so as to improve the safety and the quality of one residents life. These resources were now approved and additional staffing was in place each day to support safe community access for the resident. These staffing levels were evident on inspection and confirmed by staff spoken with. Further changes were planned once the resident transferred to their new house with a planned change from a sleepover to a waking staff arrangement. This change was resourced.

However, better assurance was needed as to how the staffing levels and arrangements in the other house were managed so that they ensured continuity and consistency of support and, supported the plans in progress to develop resident autonomy and individuality. For example, the challenge of staff working across services and the fact that four evenings each week one staff member supported both residents. The providers own annual review of the service had found that these staffing levels did limit the opportunity to provide both residents with more one-to-one support. A staff member spoken with said that residents could and did make

different choices as to what they wanted to do but in the context of the staffing levels agreement had to be reached between them. There was a residual, active but unresolved business case in this regard.

Judgment: Substantially compliant

Regulation 16: Training and staff development

From the review of the staff training matrix the inspector saw that training such as in safeguarding, fire safety, manual handling and medicines management was complete. Additional training completed by staff included a range of infection prevention and control training and site specific training on human rights and human rights based report writing, intensive interaction training and, education on restrictive practices. The person in charge said that the staff team were open to learning and to change. Refresher training was either scheduled or highlighted as to when it was due and needed to be booked.

Judgment: Compliant

Regulation 22: Insurance

The provider submitted with it's application seeking renewal of the registration of this centre evidence that it had in place appropriate insurance such as against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

There was evidence of good governance that was focused on improving the quality and safety of the service and, sustaining that improvement. The provider had consistently sought, for example from it's funding body, the resources required to improve the safety and quality of residents lives. The management structure operated as intended and there was clarity on roles and responsibilities. The provider had continued to incrementally improve its compliance with regulatory requirements. However, there were also inspection findings that were indicative of a lack of capacity in the local management systems. For example, records of staff meetings held in April and May 2024 were not available reportedly due to time constraints. More consistent oversight was needed of the completion and effectiveness of simulated evacuation drills. Better systems were needed for

monitoring the plans that were in progress for developing resident independence, choice and control. This was needed both to confirm these plans were consistently implemented but also to monitor resident engagement with the plans and their impact. There was insufficient detail for example in narrative notes seen to support such monitoring. Staff also completed daily planners and it may have been more conducive to have one recording template.The inspector was not assured that in the absence of the person in charge the management structure supported and ensured consistent management and oversight. For example, ensuring that the staff team accurately and consistently completed records such as in relation to behaviour support. There was an evident and unexplained gap in this record. In summary, based on these inspection findings there were at times deficits in the quality of the information recorded and a lack of clarity as to how that information was monitored, used and analysed. Therefore, it was unclear to the inspector how the provider was assured that "steady progress" was being made on plans and recommendations.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The person in charge discussed the planned admission of one resident to another house and described how that transfer would be managed to best support the resident. The residents family were consulted with and had accepted an invitation to visit the house.

The personal plan reviewed by the inspector contained a contract for the provision of services. However, while the contract was signed by a representative of the provider it was not signed by the resident or a representative.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed and updated to reflect both the current operation of the service and the changes planned for the service. For example, the number of residents that were accommodated and that could be accommodated and, planned changes to the purpose and function of some rooms.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had complaint management policy and procedures. There were no active complaints. Formal reviews such as the six-monthly quality and safety reviews monitored the receipt and management of complaints. The person in charge said that three of the four residents had the skills needed to raise any concerns they might have and would raise these concerns. In feedback provided by residents, the residents named specific persons and staff members that they would speak to including the person in charge if they were not happy about their service.

Judgment: Compliant

Quality and safety

The provider continued to make changes to improve the appropriateness, quality and safety of the service provided to each resident and, to improve their quality of life. Plans were still progressing in this regard. For example, the planned transition and plans to enhance the autonomy, independence, will and preferences of residents. While the inspector found there was a solid understanding of and a commitment to these changes and plans, their implementation, progress and impact was at times poorly reflected in records seen.

Each resident participated in the process of personal planning. Residents could choose if they wanted their family to participate in their personal plan or not and their choices were respected. The personal plan included the residents' personal goals and objectives.

From what the resident observed and discussed with residents, residents were busy, happy and meaningfully connected to family and society in general. Residents appeared to be embracing the increased freedom they had to make decisions about and to participate in their daily routines.

Residents did at times present with behaviour that challenged others including their peers. This could and had led to incidents between residents. Previous HIQA inspections had identified failings in how this behaviour was responded to and supported. The provider had since the last HIQA inspection commissioned an external compatibility assessment. That assessment had concluded that residents could live compatibility together but a significant change was needed in the model of support provided. While well intended, that approach had restricted and limited resident choice and control and resident potential to grow and develop. Based on what the inspector observed and discussed that change was in progress. The issue arising from this HIQA inspection was how the required change was explicitly tracked and monitored on a day-to-day basis. This has been addressed in Regulation 23.

There was evidence of input from the positive behaviour support team, psychology and psychiatry. However, there was a lack of completeness in some daily records

that did not provide assurance as to how these behaviours, their frequency, their impact and how they were responded to was consistently monitored.

The person in charge maintained good oversight of the use of planned and unplanned restrictions. The provider acknowledged that some restrictions impacted unnecessarily on a peer. It was hoped that the planned transition would result in a reduction in the use of restrictions. It would achieve a reduction in restrictions for the peer such as their access to the laundry and to the garden.

The person in charge maintained good oversight of incidents that occurred, of risks and how they were managed.

The house was equipped with fire safety measures such as a fire detection and alarm system, emergency lighting and doors with self-closing devices designed to protect escape routes. There was documentary evidence in place that these systems were inspected and tested at the required intervals. However, better oversight was needed of the procedures for testing the effectiveness of the fire evacuation procedure.

Regulation 10: Communication

There was evidence in the house of the use of a range of materials to support better and effective communication with and for residents. For example, the positive behaviour support team had provided a range of social stories in response to matters arising in the house and to support the plans in progress to develop resident autonomy. Both residents used photographs when engaging with the inspector to discuss relationships that were important to them, things that they liked to do and friends that they liked to meet. The notice board in the kitchen was similarly full of such photographs and the person in charge said that residents were very clear about what they wanted and did not want displayed on the notice board. Similarly visuals were used to support residents to make their meal choices. Plans were in progess to increase one residents access to and use of a mobile phone. Residents had access to the Internet.

Judgment: Compliant

Regulation 11: Visits

Residents were supported to maintain and develop their relationships with home and family, friends and peers. Two residents returned home to family every weekend. Family were free to visit each house and were invited by residents to social events and celebrations in the house.

Judgment: Compliant

Regulation 13: General welfare and development

The person in charge described how the MDT were consulted with and inputted into plans such as for behaviour management, transition plans and plans to develop resident autonomy and independence. Residents presented as content and busy and meaningfully engaged with family, peers and society in general. Residents showed and discussed with the inspector the things that were important to them in life such as the broad range of activities that they were involved in, meeting family and peers including inviting them to their house. Plans and actions were in progress to develop the individuality of the service and the different abilities, interests, hopes and expectations of the residents.

Judgment: Compliant

Regulation 20: Information for residents

The provider had in place a guide for residents that contained all of the required information. The inspector read the guide and it advised residents for example, as to how they would be consulted with, how to make a complaint and, the centres visiting arrangements.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the identification, management and review of risk. These systems were responsive to new risks that arose. The person in charge maintained good oversight of incidents that occurred. From the reports of the quarterly analysis of incidents the inspector saw that the person in charge reviewed each incident and how it was responded to and managed. The person in charge met with staff members to provide feedback for learning and support. The relevant risk assessments were reviewed and updated as needed.

Judgment: Compliant

Regulation 28: Fire precautions

Better and more consistent oversight was needed of fire safety. An audit had been completed of the simulated evacuation procedures completed in this house in 2023. That audit had found that only two simulated evacuations had been completed in 2023. The audit stated that a minimum of three drills were required. This meant that all staff members had not participated in a simulated drill and the audit findings stated that this was to be addressed by the end of March 2024. However, while the inspector saw that a fire drill schedule for 2024 was in place only one simulated drill had been completed to date and six staff members still had to participate in these drills. Further guidance was needed for staff as to how best to complete these drills. For example, how best to replicate a night-time scenario and how to avoid any unnecessary risks. For example, one drill had been completed while it was raining and a resident had slipped on the wet grass while evacuating.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents participated in the process of personal planning. Residents could choose if they wanted their family to have input or not into their personal plan and this choice was respected. However, the person in charge and the staff team kept families updated as appropriate in relation to any significant changes or plans. For example, the person in charge was in communication with family in relation to the planned transition of one resident.The personal plan reviewed by the inspector had been updated to include the recommendations of the compatibility assessment. The resident's personal goals and objectives (POMS) set out how the resident would be supported to develop the skills they needed to live more independently and to express their own choices and preferences. The progress of the recommendations was monitored at regular intervals by the person in charge, their line manager and the wider multi-disciplinary team. What was missing, based on these inspection findings, was the adequacy of the monitoring tools provided, the quality of the information recorded at times and, the absence of a documentary trail to evidence analysis and monitoring so as to assure the successful progression of the "pathway to independence". For example, in relation to the residents telephone skills, their use of the house key, their meal choices and preferences. This is addressed in Regulation 23: Governance and management.

Judgment: Compliant

Regulation 7: Positive behavioural support

Training was provided for staff and support was provided by the positive behaviour support team. A staff member spoken with spoke of the increased awareness the

staff team had of these behaviours and described how incidents were most likely to occur in the kitchen when one or the other resident was not meaningfully unoccupied. However, there was a lack of completeness in some records seen that did not provide robust assurance of consistent and effective behaviour support and monitoring. For example, a protocol to guide staff on how to respond to specific behaviours was unsigned and undated. A support book to be in place to guide staff was not fully complete. Staff were to record these behaviours and the peer responses. However, the inspector noted extended unexplained gaps in this record. For example, on the day of inspection the last entry noted was 14 days prior to this inspection which was highly unlikely given the frequency of the behaviours.

Judgment: Substantially compliant

Regulation 8: Protection

The person in charge clearly described the working of the providers safeguarding policy and procedures. The staff team had completed safeguarding training. Overall, the inspector found increased awareness and understanding of peer-to-peer interactions that could impact negatively on residents and the requirement to prevent and manage these incidents. It was evident from records seen that staff and residents had access as needed to the designated safeguarding officer. For example, residents in their questionnaires named the designated safeguarding officer as a person they would speak with if they had a concern or worry.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had made changes and was actively progressing plans to improve, where appropriate and safe to do so, the independence and autonomy that residents had. The person in charge described how significant changes were made so as to change the culture in the centre so that the residents led day-to-day decisions and more significant decisions in relation to their goals and objectives in life. A formal assessment had concluded that one resident had the ability to live semi-independently. While much support was needed in this regard, plans were in progress to support the resident to develop and demonstrate the skills and abilities they would need if this was to be safely achieved. Residents were spoken with and consulted with and residents reported that they had good choice and control. One resident was active in the internal advocacy forum. Since the last HIQA inspection the support of independent advocacy had been sourced for three residents to support them in progressing matters relevant to them.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 8 (1)	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Elms OSV-0004877

Inspection ID: MON-0035768

Date of inspection: 29/07/2024

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 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, by ensuring the following actions are completed: • Agenda item for upcoming team meeting includes accurate recording by staff of instances whereby one resident's choice of activity is compromising the other resident's choice. PIC to gather and analyse the data over following 3 months and ascertain if additional staffing is required. [Completion date: 31/12/2024] In addition, the provider will also: • Continue to progress resident's long-term goal of housing of his own. Consultation with the funding body will occur where additional resources are identified as required. • Continue to seek approval of residents' outstanding business case for full-time residential services; to have it in place when he does require it.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Assurances relating to the governance and management systems within the designated centre will be delivered as follows: • Team meetings are now rostered as part of staff's working hours from September onwards. Team meeting attendance requirements outlined to all staff. If not in attendance at team meetings, staff are required to read & sign the minutes of meetings. • SCW to complete minutes of team meetings and have them available to staff within 1 week of the meeting.	

• Appraisals scheduled by PIC with all staff, due to be completed by 30/09/2024. Within these appraisals, accurate and detailed report writing will be discussed with staff and their responsibility to ensure that the notes they record reflect the resident's Personal Plans and related care plans, engagement of the residents in their plans and the challenges encounter by the resident in achieving their goals. • A monitoring tool has been developed and put in place, whereby the Social Care Worker will monitor daily support notes and related records and return monitoring tool to PIC for analysis. Any gaps or deficiencies identified will be addressed with staff through team meetings or individual support and supervision meetings. • PIC will also review daily support notes bi-monthly, with the Social Care Worker. • Arising from the monitoring of daily support notes; the resident's personal plans will be reviewed and updated to reflect progress/ challenges related to their individual goals. • Compatibility assessment action plan was reviewed by the PIC & DO on 08/08/2024. Further review scheduled for 07/11/2024 with PIC, DO, Community Manager & external consultant contracted to carry out assessment. [Completion date: 30/09/2024]

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre. This will be ensured by: • Individual Service Agreements have been signed by all residents or their representatives. Completed: 06/08/2024.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. This will be ensured by: • All remaining staff to complete a fire drill before 30/09/2024. • Sample fire drill report will be circulated to all staff at team meeting scheduled for 03/09/2024, to guide their future recording of same. • PIC will monitor fire drill schedule and fire drill reports quarterly. • Fire safety is a standing agenda item at team meetings, and the fire drill schedule will be discussed at each meeting. [Completion date: 30/09/2024]	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:	

The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. This will be ensured by:
• Further development/ enhancement of the resident's behaviour support book will be carried out.
• All protocols in place relating to supporting residents' behaviour have been signed and dated.
• Behaviour recording charts will be monitored by the SCW & PIC, in conjunction with PBSS.

[Completion date: 30/09/2024]

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2024
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.	Substantially Compliant	Yellow	30/09/2024
Regulation 24(3)	The registered provider shall, on admission, agree	Substantially Compliant	Yellow	06/08/2024

	in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/09/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/09/2024