



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

Name of designated centre:	Esmonde Gardens
Name of provider:	St Aidan's Day Care Centre Limited by Guarantee
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	22 August 2018
Centre ID:	OSV-0001855
Fieldwork ID:	MON-0024560

About the designated centre

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

The centre was registered 2015 to provide long-term care to 11 adults, both male and female, with diagnosis of mild to moderate intellectual disability, mental health , dual diagnosis and behaviors that challenge. Residents who have additional nursing care needs are also supported in one residential unit which is specifically set up for this purpose.

The centre comprises of two residential units and one standalone self-contained apartment. The residential units accommodate up to 3 and 7 residents respectively, while the apartment can accommodate one resident. The self-contained apartment was not occupied at the time of this inspection. There were a number of day services / workshops allied to the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10
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How we inspect

To prepare for this inspection the inspector or 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
22 August 2018	10:00hrs to 19:00hrs	Noelene Dowling	Lead

Views of people who use the service

There were 10 residents living in the centre at the time of the inspection. The inspectors met with five of the residents and spoke with one, who indicated happiness with the service. Others communicated in their preferred manner and allowed inspectors observation of their routines and activities.

Capacity and capability

This inspection was to assess the effectiveness of the actions taken by the provider to address the concerns raised by HIQA on the last inspection and to ensure that the centre was being appropriately monitored as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (The Regulations).

The previous inspection of the centre in April 2018 identified a number of significant non-compliances which raised concerns about the capacity of the provider to appropriately govern the centre. Concerns were also raised about the capacity of the provider to safeguard residents and provide appropriate care arrangements for their long term care needs.

As a result of these concerns the HIQA took escalated action and issued a notice of proposal to refuse the renewal of registration on 30 May 2018. The provider had made representation in response to this notice which was being given consideration by the Office of the Chief Inspector at the time of this inspection. The inspection also assessed the actions taken by the provider as set out in this representation.

Overall, it was found that the provider had made significant improvements, however, further improvement was needed. Sixteen regulatory non-compliance's were found at the last inspection, seven of these had been fully addressed in a timely manner. However, action had been taken and works commenced in relation to the outstanding non-compliances. The matter of the long-term and interim accommodation plans for the residents living in the largest of the residential units was not progressed or adequately planned for.

However, inspectors found that the provider had made significant progress in putting staff and systems in place to improve the governance structures and to oversee the safety and quality of care in accordance with the representation made.

Systems of governance had improved, however, improvements were needed. Revised structures had been implemented with clearly defined roles and responsibilities for those involved. A new and full time person in charge with sole responsibility for this centre and protected time to carry out the duties had been appointed. The person was already working in the organisation and therefore was very familiar with the residents and the centre. This allocated time was found to allow the person carry out their duties. The person in charge advised that arrangements were suitable and they were well supported in their role. Inspectors found the duties of the person in charge were clearly defined and carried out effectively.

There was evidence of improved reporting and accountable structures at all levels with evidence of more direct involvement by the board, and regular meetings between CEO and the person in charge. Systems for monitoring and safety at local and board levels had also been enhanced. The records reviewed demonstrated improved communication reporting and planning. This facilitated better oversight of residents care and direction of staff practices.

The provider representative and the person in charge were seen to be very familiar with and engaged with the residents.

Some improvements were still required to consolidate the governance systems and ensure they were effective and sustainable. The quality management systems had been improved with regular auditing and reporting of incidents. However, the auditing systems were not robust or sufficiently extensive in content to allow for better review of practices and learning for the provider. That said, all incidents were reviewed as they occurred and had significantly reduced in this centre.

In addition, the content of the unannounced visit by the provider did not identify any areas for quality improvement. The unannounced visit is a key component of the monitoring process and is intended to facilitate the provider to self identify issues and address these issues in a proactive way. In this case the unannounced visit did not address key areas for improvement, some of which were known to the provider, such as the need to review the compatibility of residents, numbers in individual residential units or changing healthcare needs. At the feedback meeting the provider representative advised that future unannounced visits would be undertaken by an external person which would provide a more objective review.

The provider had made good progress in relation to managing the workforce. Staffing levels and deployment arrangements had been significantly increased to address residents need for individual supports, supervision and activities. Staff advised inspectors that these changes to the structures provided more effective support and guidance to them.

The provider was actively seeking to employ a clinical lead as director of care and to support the CEO and the persons in charge in the organisation as a whole. The provider was also actively seeking to strengthen oversight of the service by the board of management. The Chairperson of the board outlined plans to increase the number of suitably experienced board members.

Recruitment procedures were carried out satisfactorily and staff supervision was taking place with evidence of good induction undertaken.

The provider's systems for managing complaints required improvement. For example, an un-resolved concern noted at the previous inspection regarding a resident's expressed unhappiness had been made at a multidisciplinary review. While the provider had spoken with and engaged with the resident about some of the issues, the substantive of the complaint were not addressed. The length of time which had elapsed also impacted on this. This is of concern as it does not demonstrate that the provider recognises and is acknowledging the inherent difficulties in the centre and the need to act to address this.

The statement of purpose is a key governance document which sets out how the centre is to run and what residents and staff can expect to see in the service. It is required to be kept up to date and under regular review. This document required some review to detail the precise number of residents to be accommodated in the designated centre.

Regulation 14: Persons in charge

The person in charge was suitably qualified, dedicated to this centre and had good oversight of the residents care needs.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels had been significantly increased which ensure residents care needs and preferences were being met.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training and supervision was satisfactory.

Judgment: Compliant

Regulation 23: Governance and management

Some ongoing improvements were still required in the management systems and structures to ensure effective oversight of the service. The provider's ability to self identify areas for improvement, respond to changing needs and plan strategically for these was not demonstrated.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The admission procedures and contract for service were satisfactory .

Judgment: Compliant

Regulation 3: Statement of purpose

Some changes were required to correctly identify the number of residents which can be accommodated in the centre and the numbers applied for in the application for registration.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge was forwarding the required notices to HIQA

Judgment: Compliant

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

The provider had complied with the requirement to notify HIQA of the absence of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

While the provider did act to address a complaint made, the actions taken did not demonstrate that the substantive issue had been addressed or was being acted on by the provider. The actions did not sufficiently take account of the nature of the residents disability or the length of time since the issue was raised.

Judgment: Substantially compliant

Quality and safety

The provider had made a number of proposals in the representation to HIQA as to the steps to be taken to improve regularity breaches in safeguarding and residents welfare. It is acknowledged that works had commenced in relation to all actions but some improvements were still required in systems for managing safeguarding issues, adequate review for residents, risk management and planning for residents via the multidisciplinary reviews.

The staffing levels had been significantly increased which ensured residents had access to good levels of individual supports and participated in the activities they enjoyed. This also supported residents advancing age and healthcare needs. They could if they wished remain at home or have lie-ins and a rest which reflected good person centred practice.

Residents healthcare needs continued to be well managed and the person in charge provided good oversight and clinical review. Full time nursing care was required for some residents and this was available as indicated in the statement of purpose. At the time of the inspection staff were allocated to remain with a resident in hospital to ensure their needs were understood and met. There was evidence of increased physical care needs emerging for some residents. Additional staffing had been made available and additional assistive equipment was being sourced to address this and support the resident. However, the size and location of the bedroom and bathroom did not facilitate easy movement for the resident.

The provider had further work to do to improve their safeguarding systems. Previous actions in relation to safeguarding plans and recognition of potential abuse and reporting of allegations made had been addressed. Reports were forwarded to the relevant agencies. However, systems for ongoing follow up and monitoring by the provider of the progress in relation to these, and support for residents where allegations may take significant time to be investigated was not evident. The internal processes used when managing allegations were not adequately recorded to ensure they were safe and transparent. For example, one record seen by inspectors contained a withdrawal of an allegation written on behalf of the resident by a staff.

The details of how this withdrawal had been sourced were not included in the safeguarding report or forwarded to the HSE safeguarding office. Inspectors could not ascertain if this process had been reviewed by the person in charge or the provider. This indicates that there is still some improvement necessary in clarity of ongoing responsibilities in relation to such matters although the systems had been much improved.

There was increased access to clinical assessments/ behaviour supports and training for staff in the management of behaviours that challenged. This process was ongoing. Key members of staff were included in the behaviour support committee and there were regular reviews with the external specialist for key staff. Inspectors found that there had been a reduction in incidents of behaviours that challenged and internal safeguarding issues. The additional staffing levels had also supported this finding and staffs were very familiar with the residents needs in this regard.

The action required from the previous inspection in relation to the lack of privacy with viewing windows in bedrooms and bathrooms had been satisfactorily addressed. A pertinent risk assessment had been undertaken and timed nightly checks were now only undertaken on those residents whose needs dictated this.

The actions in relation to the management of fire safety and evacuation of residents had been partially but not fully resolved. Revised fire safety training had been provided and practice in the use of ski sheets had had taken place. However, there were no strategies devised for the important matter of supporting residents who had not previously complied with the evacuation procedure. Adequate testing of the alarms and practice in the evacuation procedures had been undertaken in one of the units as required by the previous inspection.

A risk management policy had been devised and there was a detailed risk register in place. However, this was organisational as opposed to centre-specific and therefore not a working tool for the person in charge to assess and monitor the risks pertinent to this centre and the residents, such as the fire evacuation procedures. This policy required some further review to ensure that it guided effective practice on the ground.

There were a number of ongoing premises and compatibility issues which had not yet been addressed by the provider. The provider had informed HIQA that a number of processes were being undertaken to ascertain residents' preferences in relation to their living arrangements. This process had not been completed at the time of inspection. In addition, the provider had advised HIQA that two additional housing units were to be provided, one five bed and one seven bed two story unit. The precise use of these units was to be confirmed. However, these housing units were at the planning stage and in the interim the provider did not have definitive plans to address the issues of residents' differing needs, changing physical needs, levels of vulnerability and compatibility issues in the existing residential units.

It was noted that the current seven bedded unit was small and given residents changing needs and requirements for additional equipment this compounded the difficulties. Staff tried to manage these issues by for instance,

residents having meals in different areas of the unit. The overall communal space including the kitchen area could not comfortably accommodate the number of residents and the mobility equipment.

Residents had relevant and detailed support plans in place which were reviewed regularly. The residents' social care needs and preferences continued to be well supported with good access to social activities, the community and their families. Residents were seen to be busy with their daily activities and comfortable with the staff.

The use of restrictive practices was minimal but some improvements were necessary in the protocol for and review of the use of medication to manage behaviours that challenged. However, plans for the management of other pertinent risks such as potential self-harm were detailed.

Regulation 17: Premises

The suitability of the premises to provide for the current number of residents required review. The provider was taking some proactive steps to ascertain residents' preferences about their preferred living arrangements but no definitive plans were in place.

Due to the changing physical care needs of a resident the premises in its current configuration required review with regard to the location of bedroom and bathroom accommodation .

Judgment: Not compliant

Regulation 26: Risk management procedures

Some changes were required in the systems for addressing risks specific to the centre and monitoring the action taken. The risk management policy did not provide adequate guidance to staff in this regard.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While changes had be made to the systems for fire evacuation no strategies had

been devised for the substantive matter of residents refusing to evacuate.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Improved support was in evidence however some significant issues had not yet been addressed. Residents had very detailed assessments and personal plans. While these were reviewed regularly, the long term needs of the residents in terms of different and changing needs were not reviewed via the multidisciplinary review process. In addition, the varying needs and compatibility of residents did not allow for the meeting of each individual's needs.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to have the best possible health with good clinical review and monitoring.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had increased access to clinical supports for behaviours that challenge and staff were given appropriate guidance to manage this.

Judgment: Compliant

Regulation 8: Protection

Despite the training and policy in safeguarding there was evidence that further knowledge and understanding was required in systems for managing allegations, oversight of outcomes of allegations, and in providing ongoing supports to residents in situations where, despite reporting of allegations no outcome may be possible.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The un-necessary and intrusive viewing panels in residents. bathrooms and bedrooms had been removed since the previous inspection.

There was evidence that residents were consulted regarding regarding their daily routines and preferred activities.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Esmonde Gardens OSV-0001855

Inspection ID: MON-0024560

Date of inspection: 22/08/2018

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 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Management Oversight:</p> <ul style="list-style-type: none"> • The organisation continues to actively recruit a CNM3. We have commissioned Hartley People Recruitment Company, Waterford to source this individual. This recruitment agency have advised that they have had a number of expressions of interest in the position. They have advised that they have advertised on Irish Jobs which aggregates to 40 job advert sites. They are also contacting individuals on Linked-in. HIQA will be kept updated in relation to this matter. • In the interim the CEO is supported by a Senior Staff Nurse with a management qualification and past experience as a Clinical Nurse Manager in residential services. She is knowledgeable and familiar with regulation and the HIQA standards. This individual is in a full time position and has the autonomy to make decisions if and when required. This individual also acts up in the absence of the CEO/Service Provider. She works very closely with the PIC’s and the CEO/Service Provider & HR Manager. <p>Update: 30th November 2018</p> <ul style="list-style-type: none"> • The organisation had an identified gap in the management structure i.e. there was no CNM3 in position. The organisation have now successfully recruited a Quality & Clinical Compliance Manager/CNM3 who is due to commence employment on 3rd December 2018. This individual will be responsible for the oversight of this designated centre. The PIC will report directly to the CNM3. The CNM3 will report directly to the CEO/Service Provider and the CEO will report to the Board of Directors. • This will ensure clearly identified management structure in this designated centre. <p>Board Member:</p> <ul style="list-style-type: none"> • The Governance Officer on the board has approached an individual with a clinical 	

background and has experience in auditing in the HSE and this individual is considering becoming a member of the Board.

Update: 30th November 2018

- The board have made contact with an individual with clinical background who also has experience in auditing. This individual is currently recovering post op and further contact will be made by end of December by the Board member to confirm when they will be in a position to be co-opted onto the Board of Directors.

Quality of auditing:

- Audits of physical intervention used, the use of chemicals for behavior's that challenge, the use of PRN for pain will now be recorded on the KPI template, and will be reviewed monthly by the PIC's and Senior Management for learning. This learning will be discussed by the PICS at their monthly meeting.
- The learning from the findings will be discussed at the Quality, Health and safety risk management committee meetings and shared at staff meetings.

Update: 30th November 2018

- The Key Performance Indicators have been reviewed and now record and reflect PRN's administered for behaviour and pain management. These KPI's will be reviewed monthly and the trends and learning are identified and discussed by senior management and the PIC.

Unannounced Inspection:

- The unannounced inspection report will include a written report on the safety and quality of care and support provided in the centre and a strategy plan will be put in place to address any concerns regarding the standard of care and support evidenced during the unannounced inspection.
- This will be included in the body of the report and in a QIP at the end of the report.
- The unannounced inspection will be discussed at the Quality, Health & Safety Risk Management Committee, the PIC's and with the staff working in the designated area.
- The Service Provider has made contact with an external company who has agreed to provide auditors to carry out unannounced inspections on this designated center by the end of 2018.
- The findings and recommendations from these unannounced inspections will be actioned on for quality improvement and a report will be furnished to the Board of Directors, CEO and Senior Management and discussed at the Quality, Health and safety risk management committee meetings.

Planning for residents future care:

- A number of consultation meetings have taken place between the service and the Disability Co-Ordinator HSE in relation to the residents compatability and future care needs and living arrangements. At a meeting on 22nd October, dates were confirmed for annual MDT meetings
- 30th October – planning meeting for both designated centres
- 6th November – MDT meeting with families
- 20th November – MDT meeting with families
- 27th November – MDT meeting with families

- The HSE Disability Co-Ordinator has now committed to attending multidisciplinary reviews and they will occur annually or more frequently if required. These MDT meetings will review the overall health & wellbeing of the individual and suitability of their residential placement. An MDT template has been devised in collaboration with the HSE Disability Co-ordinator and St. Aidan's Services in line with the HIQA themes.
- A definitive plan is now in place to address the residents' wellbeing which is being impacted on by the complex needs in this designated centre as follows:-
 - Two residents with complex needs have been identified using the DSMAT Tool. It has been agreed in collaboration with the HSE that these two residents will be forwarded to the Executive Residential Committee for review at the November 2018 meeting. The DSMAT- Disability Supports Application Management Tool captures information regarding individual information, diagnosis, risk and safeguarding issues, mental health, medical support needs and home circumstances. It also outlines the reason for the application e.g. changing needs in the home, changing needs in the existing service.
 - This process will be carried out in collaboration with the residents and their family members.
 - Permission was sought from Cluid Housing at a planned meeting on 23rd October as protocol when any changes are being made to the internal structure of the house to have a bedroom adapted to meet the needs of the individual identified in the HIQA report who's current bedroom and bathroom requires review. At a further meeting on October 30th, permission was given by Cluid Housing Engineers for St. Aidan's Services to commission an independent engineer to look at the structure of the home in relation to the above.
 - An identity profile/mapping exercise has been carried out on all the residents. The results of this profile is being discussed at each residents MDT annual review meeting. The findings will also be shared with the Quality Health and Safety Risk management committee to ensure the best possible standard of care is offered to all residents.
 - The purpose of this mapping exercise is to review the compatibility and complex needs of all residents residing within our residential services to identify if there is a more compatible mix of our residents residing together.
 - This process will be carried out in collaboration with the residents and their families and the HSE.
 - In relation to the completion of the new build home. We have been advised by Wexford Co Council that the planning application will be lodged shortly; a part 5 agreement in principal has been reached between the parties. We have been advised from the time the planning application is approved it will take approximately one year. We will keep HIQA informed during each stage of the process.
 - As soon as designs and costs are agreed St. Aidan's can then apply for funding under CAS. Wexford Co Council has advised that they will support this application.
 - It has been agreed that this home will be purpose built as a residential home to care and support the needs of the older person in our residential service.
 - It is proposed that 2 service users from Esmonde Gardens and 2 from Woodlands/Crossroads will relocate to this new residential home.

Update: 30th November 2018

- All residents have had an MDT meeting.

- One individual was referred into DSMAT and the 2nd is being referred into the December meeting. The individual that was referred in has been assessed by a private service for a rolling respite. The resident fully engaged in this process. The representative from this private service met with the resident on 28th November and they are in collaboration to the HSE in relation to providing this service. Another agency has agreed to assess this individual for longterm placement in the New Year.
- The Disability Co-Ordinator, HSE is referring the 2nd Resident into Acquired Brain Injury for an assessment on 29th November 2018.
- In collaboration with the HSE OT, resident and family. This individuals room has been reconfigured to meet his needs. The OT has assessed and reviewed the bedroom and bathroom facilities for this resident and has confirmed in writing that at present they meet the needs of this resident. (See attached OT letter).
- We await an independent engineers report in regarding the structure of the home and adapting one of the bedrooms into an en-suite room.

Development of new build:

- As identified this home has seven residents with diverse complex needs. It is proposed to relocate two residents to a new purpose built home to meet their changing needs. Since last inspections plans are with Wexford Council. Phase 1 of this building project has commenced and the 2nd Phase in which this property is planned will take place in 2019. A CAS application will be supported by the Wexford Co Council

Regulation 3: Statement of purpose	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 3: Statement of purpose:</p> <p>The recommendations made during the HIQA inspection was taken on board and amended in the statement of Purpose. This was summited to HIQA on the 14th September. The statement of purpose will be reviewed and updated if required by the PIC's at each quarter and the findings will be discussed with senior management.</p> <p>Update: 30th November 2018</p> <ul style="list-style-type: none"> • Statement of Purpose has been amended and in place in the residential home and should any changes be made to the home it will be reflected in the SOP. 	
Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Following the feedback meeting the CEO/Provider contacted TÚSLA for an update in relation to the substantive issue noted in the report. TÚSLA has acknowledged the referral and that its investigation is ongoing regarding the risk to children. TÚSLA has referred the case to the Gardaí and advice given is that the service report any additional information they have to the Gardaí separately. The PIC has contacted the Gardaí and was informed that they were aware of the case and the liaison Garda will be in contact with the resident. The PIC will review this regularly with the liaison Garda.

Regarding safeguarding, to allow for informed feedback the recommendation made by HSE Safeguarding Officer is to send a retrospective referral to safeguarding and to carry out a preliminary screening which will contain a safeguarding plan. This request has been completed and safe guarding plan has been updated.

An accessible and age appropriate format complaints procedure will be devised and will be appropriate to the needs of residents in line with their age and nature of their disability.

Update: 30th November 2018

- A draft easy read format of the services complaints procedure which includes an appeals process has been developed and will be available to all residents by end of December 2018. This document has been disseminated to all services for discussion.

Regulation 17: Premises

Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

- A definitive plan is now in place to address the residents' wellbeing which is being impacted on by the complex needs in this designated centre as follows:-
- Two residents with complex needs have been identified using the DSMAT Tool. It has been agreed in collaboration with the HSE that these two residents will be forwarded to the Executive Residential Committee for review at the November 2018 meeting. The DSMAT- Disability Supports Application Management Tool captures information regarding individual information, diagnosis, risk and safeguarding issues, mental health, medical support needs and home circumstances. It also outlines the reason for the application e.g. changing needs in the home, changing needs in the existing service.
- This process will be carried out in collaboration with the residents and their family members.
- Permission was sought from Cluid Housing at a planned meeting on 23rd October as protocol when any changes are being made to the internal structure of the house to have a bedroom adapted to meet the needs of the individual identified in the HIQA report who's current bedroom and bathroom requires review. At a further meeting on October 30th, permission was given by Cluid Housing Engineers for St. Aidan's Services

to commission an independent engineer to look at the structure of the home in relation to the above.

- An identity profile/mapping exercise has been carried out on all the residents. The results of this profile is being discussed at each residents MDT annual review meeting. The findings will also be shared with the Quality Health and Safety Risk management committee to ensure the best possible standard of care is offered to all residents.
- The purpose of this mapping exercise is to review the compatibility and complex needs of all residents residing within our residential services to identify if there is a more compatible mix of our residents residing together.
- This process will be carried out in collaboration with the residents and their families and the HSE.
- In relation to the completion of the new build home. We have been advised by Wexford Co Council that the planning application will be lodged shortly; a part 5 agreement in principal has been reached between the parties. We have been advised from the time the planning application is approved it will take approximately one year. We will keep HIQA informed during each stage of the process.
- As soon as designs and costs are agreed St. Aidan's can then apply for funding under CAS. Wexford Co Council has advised that they will support this application.
- It has been agreed that this home will be purpose built as a residential home to care and support the needs of the older person in our residential service.
- It is proposed that 2 service users from Esmonde Gardens and 2 from Woodlands/Crossroads will relocate to this new residential home.
- When this process is complete these residential beds will not be reoccupied.

Update: 30th November 2018

- In collaboration with the HSE OT, resident and family. This individual's room has been reconfigured to meet his needs. The OT has assessed and reviewed the bedroom and bathroom facilities for this resident and has confirmed in writing that at present they meet the needs of this resident. (See attached OT letter).
- We await an independent engineer's report in regarding the structure of the home and adapting one of the bedrooms into an en-suite room.

Development of new build:

- As identified this home has seven residents with diverse complex needs. It is proposed to relocate two residents to a new purpose built home to meet their changing needs. Since last inspections plans are with Wexford Council. Phase 1 of this building project has commenced and the 2nd Phase in which this property is planned will take place in 2019. A CAS application will be supported by the Wexford Co Council

Regulation 26: Risk management procedures	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

- The risk register will be centre specific and therefore a working tool for the person in charge to assess and monitor the risks pertinent to this centre and the residents which will include fire and the use of PRN for chemical restraint.

Update: 30th November 2018

- Changes were required in the systems for addressing risks specific to the centre. The risk register has been reviewed and updated to include fire and PRN for chemical restraint.

Regulation 28: Fire precautions

Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- In relation to the Fire precautions and fire evacuation, and in relation to residents identified as having challenges and having not complied previously with the evacuation procedure was discussed at a staff meeting and the following strategies were put in place:-
 - A residents meeting was held and the issue of the fire safety and evacuations was discussed. Members of the local fire service have been invited to attend a meeting in the home and have been asked to explain the importance of all residents responding to the fire alarm.
 - One resident identified by staff as having difficulties responding, was supported throughout the meeting.
 - Three fire drills were carried out over a period of 3 weeks to support staff and residents in implementing new strategies. The residents co-operated very successfully with the evacuations which included the additional supports applied.
 - Members of the fire service have agreed to carry out an annual fire walk through of the residential buildings to support staff and residents and to familiarise themselves with the premises.
 - All residents PEEP's have been reviewed and updated.

Update: 30th November 2018

- Following the last inspection and the implementation of strategies service users are now engaging in the fire evacuations without any issues. Individual person centred PEEP's have been updated. A meeting was held with the local fire servicemen with the residents and they have committed to returning to the home to carryout a fire evacuation with the residents and staff in the home.

Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <ul style="list-style-type: none"> • A number of consultation meetings have taken place between the service and the Disability Co-Ordinator HSE in relation to the residents compatability and future care needs and living arrangements. At a meeting on 22nd October, dates were confirmed for annual MDT meetings • 30th October – planning meeting for both designated centres • 6th November – MDT meeting with families • 20th November – MDT meeting with families • 27th November – MDT meeting with families <ul style="list-style-type: none"> • The HSE Disability Co-Ordinator has now committed to attending multidisciplinary reviews and the will occur annually or more frequently if required. These MDT meetings will review the overall health & wellbeing of the individual and suitability of their residential placement. An MDT template has been devised in collaboration with the HSE Disability Co-ordinator in line with the HIQA themes. • During unannounced inspections the provider will ensure that the outcome of the MDT meetings and PCP meetings are being actioned on. • A definitive plan is now in place to address the resident’s wellbeing which is being impacted on by the complex and different needs and changing needs and behaviours in this designated center. <p>Update: 30th November 2018</p> <ul style="list-style-type: none"> • A mapping exercise was carried out to ascertain what residents would be more compatible to live with each other. A plan has been put in place which includes two resident being assessed for an appropriate placement to meet their needs. • All of the residents in this designated have had a MTD meeting with the Disability Co-Ordinator - HSE, their Keyworkers from day and residential services, PIC & family member were in attendance. An MDT template document was used at these meetings to capture the changing/complex needs and compatibility of these residents. 	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <ul style="list-style-type: none"> • The PIC and Service Provider will ensure that the withdrawal of an allegation by a resident will be included/recorded in the residents safeguarding report. Records show that this information was forwarded to the HSE Safeguarding Officer on 24th July 2018. • The PIC met with the Provider and SCL to discuss and review the process on 18th 	

September 2018.

- In relation to the substantive issue noted in the report the PIC will continue to support the resident and has contacted the Gardaí and was informed that they were aware of the case and the liaison Garda has advised that they will be in contact with the resident. The PIC will review this regularly with the liaison Garda.
- The PIC will ensure that all staff are trained in relation to safeguarding, protection and response to abuse.

Update: 30th November 2018

- The PIC has made contact with the liaison Garda and is awaiting confirmation of a date for the Garda to meet with the resident in question.
- The organisation's safeguarding officer has reviewed the safeguarding plan and has furnished the HSE Safeguarding team with an updated plan.

Intimate Care

• The service is currently developing an intimate care policy which will be completed by 16th November 2018. The aim of this policy is to give direction to staff with regard to supporting individuals in their intimate care needs in a way which promotes the dignity and privacy of the service user while also protecting the integrity of the staff involved. This policy will apply to all staff involved in supporting individuals who use the service with regard to their intimate care needs.

Update: 30th November 2018

- The intimate care policy is now in place.

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 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	31/05/2018
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	31/12/2018
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Not Compliant	Orange	31/12/2018

	carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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.	Substantially Compliant	Yellow	23/11/2018
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.	Not Compliant	Yellow	28/09/2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of	Substantially Compliant	Yellow	29/08/2018

	purpose containing the information set out in Schedule 1.			
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.	Substantially Compliant	Yellow	09/11/2018
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	24/09/2018

Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	16/11/2018