Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Woodlands/Crossroads
Name of provider:	St Aidan's Day Care Centre Limited by Guarantee
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	23 August 2018
Centre ID:	OSV-0001858
Fieldwork ID:	MON-0024561

About the designated centre

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

The service provides long-term residential care to 12 residents, both male and female who have a primary diagnosis of moderate to severe intellectual disability, secondary mental health diagnoses and behaviours that challenge. The centre comprises two interlinked buildings with six individual bedrooms in each. Rooms are spacious and fitted with all the necessary equipment and assistive devises needed for the residents .The buildings which make up the centre are homely, bright and comfortable. There are suitable safe gardens and it is within easy access of all local facilities and services. There is a day service on site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
23 August 2018	08:00hrs to 15:00hrs	Noelene Dowling	Lead

Views of people who use the service

Inspectors met with 5 residents and spoke with three. Other residents allowed the inspectors to observe some of their daily routines and communicated in their preferred manner with staff assistance. Residents told inspectors that they were satisfied with the service provided to them.

They continued to enjoy their training centres and jobs and their various social activities. Some residents did also again indicate that the noise levels could be difficult at times.

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 February 2018 identified a number of significant non compliances which raised concerns about the capacity of the provider to appropriately govern and manage the centre. Concerns were also raised about the capacity of the provider to manage compatibility issues, safeguard residents and provide appropriate care arrangements for their long term care needs.

As a result of these concerns 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 the provider had taken a range of measures to address the concerns raised by HIQA since February 2018. However, while some areas of non compliance had been addressed satisfactorily and had brought about improvements the crucial issues of the interim and long term accommodation plans for the residents living in the centre were not progressed and

no definitive plans had been made to do so.

However, inspectors found that the provider had made significant progress in strengthening the governance of the service. There were better arrangements in place for staffing and personnel. This improved the capacity of the provider to govern the centre and to oversee the safety and quality of care. These changes were in accordance with the representation made.

Revised structures had been implemented with clearly defined roles and responsibilities for those involved. This included the appointment of a new person in charge with sole responsibility for this centre in April 2018 and protected time to carry out the duties. This allocated time was found to be sufficient but the provider undertook to keep this under review. The duties of the person in charge were clearly defined. Although new to the post the person was receiving good support from the CEO to ensure she was familiar with the responsibilities and the role. There was also an additional qualified nurse who worked opposite the person in charge to ensure communication and consistency.

There was evidence of improved reporting structures to the board of management, more direct involvement by the board, and regular meetings between CEO and the person in charge. This facilitated better oversight of resident care needs. It was apparent that the management team were very familiar with and engaged with the residents and actively working to achieve compliance.

However, some matters identified in the quality and safety section of this report indicate that improvements are still required in governance to be fully accountable for the direction of practices in the centre and demonstrate the capacity to self identify issues and take appropriate action to address these issues.

This was demonstrated in the quality of auditing and unannounced visit to the centre. Quality management systems had been improved with regular auditing and reporting of incidents, which were reviewed as they occur. However, the auditing systems were not robust or extensive. For example; there were no audits of physical intervention use or the use of chemicals for behaviours that challenged. While individual incidents were responded to there was no no evidence of learning, review or how changes were transmitted to the staff group.

The content of the unannounced visit by the provider did not sufficiently identify areas for quality improvement in the service including the need to review the compatibility of the residents and suitability of the care arrangements. Although aware of the concerns regarding the compatibility of the residents there were no interim or long-term plans made to address this.

Inspectors found that the provider had demonstrated good practice in their staffing arrangements for the centre. 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 also actively seeking to employ a clinical lead as director of care in

order to support the CEO and the person in charge in the organisation which would also improve oversight and direction of practices. The timescale which the provider had allocated for recruitment to this position however, did not reflect the urgency of the need for increased capacity in this area. The provider was also actively seeking to increase the number of suitably experienced board members.

Recruitment procedures were carried out satisfactorily and staff supervision was taking place although in a limited capacity. No complaints were recorded at this time in this centre.

Regulation 14: Persons in charge

A full time suitably qualified person in charge of the centre had been appointed with protected hours to undertake the duties involved.

Judgment: Compliant

Regulation 15: Staffing

The numbers of staff had been significantly increased which supported residents well being and activities.

Judgment: Compliant

Regulation 16: Training and staff development

Satisfactory arrangements were in place for ongoing staff training and development.

Judgment: Compliant

Regulation 23: Governance and management

While significant improvements had been made in the structures roles and responsibilities of the management team some improvements were still required in systems for oversight, monitoring of care and practices , planning for residents future care and in the capacity to assess the the service for quality improvements.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required some minor amendments to reflect the recent changes, the numbers of residents and the staffing levels.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Satisfactory arrangements were in place to notify the office of the chief inspector about key prescribed information.

Judgment: Compliant

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

The provider has forwarded the required notifications as to periods of absence or changes to the person in charge.

Judgment: 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 deficits in safeguarding and residents welfare identified at the previous inspection. It is acknowledged that works had commenced in relation to all actions but some improvements were still required in systems for robust oversight of practices and adequate review and planning for residents' future

needs.

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. Increased access to clinical assessments, behaviour supports and training for staff was also evident. All of this supported an improved quality of life for residents.

The health and social care preferences and needs of the residents continued to be well monitored and promoted with suitable support plans implemented. Primary care of residents was found to be of a good standard and they continued to have access to social activities of their choosing. Actions required from the previous inspection in relation to the lack of privacy with viewing window panels in bedrooms and bathrooms had been satisfactorily addressed. A pertinent risk assessment had been undertaken and nightly checks were now only undertaken on those residents whose needs dictated this. An additional small sitting room had also been provided in one unit to allow for more personal space for residents in a quiet and clam environment.

However, despite these improvements and the changes to the governance structures inspectors found that more robust attention and oversight to specific aspects of residents' care was still required to ensure the changes were embedded in practice.

For example, safeguarding plans required more specific detail and ongoing monitoring to ensure they adequately guided staff in protecting residents who could not protect themselves in some instances. In addition, the provider had been required to implement a framework for the management of statements made by residents which could be indicative of abusive interactions. These had been assessed by the provider as being primarily behavioural although no review of these had taken place. A protocol had been devised to manage this issue but the records seen did not indicate that this was fully understood or followed in a transparent manner in order to ensure there was no actual risk or harm to the resident despite these behaviours.

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 some reduction in incidents of behaviours that challenged. More tailored day-care arrangements had also been made to promote better behaviour supports with consistent one-to-one staff providing this in some instances. However, in one instance observed during the inspection it was apparent that the staff did not have training in supporting the resident and the person in charge confirmed this. In another incident seen the staff had not been informed that personal alarms were to be worn which placed the staff and other residents at risk. It was not demonstrated what precise actions were taken to effectively ensure this did not reoccur.

A review of the records and incident reports demonstrated that incidents were still occurring in the centre which impacted either directly or indirectly on other residents' wellbeing in the home. This was also directly observed during the

inspection. The records of the incidents maintained did not provide sufficient detail so as to adequately review the effectiveness of the behaviour support plans and staffs implementation of them. In some instances seen by inspectors full reports were not completed. As a result the provider was not demonstrating the capacity to effectively respond to and mange ongoing issues associated with behaviours that challenge and the impact this was having on residents.

The provider had informed HIQA that a number of reviews were being undertaken to ascertain residents' preferences in relation to their living arrangements. These had not been completed at this time and there were no definite plans in relation to the outcomes. In addition, the provider had advised HIQA that two additional housing units were to be provided. The precise purpose of the units was not outlined and the provider had no plans to address the issues of residents' different needs, levels of vulnerability and compatibility at this time.

This finding was also compounded by the lack of comprehensive multidisciplinary reviews of the residents, which would have provided an appropriate mechanism for such planning. Inspectors did see evidence in some records of the recognition of impact of behaviours on other residents but these did not form part of any planning process.

While the use of restrictive practices was minimal the monitoring of their use still required some improvements. For example, the records of one physical intervention did not accurately detail what had been done and where as required medication had been used this was not reviewed to ensure they were in accordance with policy and protocol. There was no evidence that they were used inappropriately but this lack of review could pose a risk to residents' safety and could adversely impact on their rights.

Intimate care plans also still required review to ensure they were appropriate and took account of the resident's dignity and bodily integrity.

A risk management policy had been devised and there was a detailed risk register. However, risks were not fully reviewed as incidents occurred. For example, this was demonstrated by the failure to address the personal alarm and the unsafe location of the medicines cabinet had not been addressed.

These findings indicate that while the systems for oversight had been devised their implementation still required attention to ensure they became embedded in practice

Regulation 26: Risk management procedures

The process for assessing pertinent risks and responding to identified risks required some improvements to be fully effective .

Judgment: Substantially compliant

Regulation 28: Fire precautions

Residents personal evacuation plans had been reviewed to ensure they could be evacuated from centre if necessary.

All fire safety management equipment had been serviced as required.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

While residents had pertinent assessments and plans these were not adequately or comprehensively reviewed to ensure they were suitable and effective in meeting the residents' needs and ensuring the living arrangements remained suitable.

Residents' wellbeing was impacted on by the different needs and behaviours in the centre and the lack of long-term or interim plan to address this. The provider was required to ensure that the centre could appropriately provide for the needs of the current residents.

Judgment: Not compliant

Regulation 6: Health care

Residents health care needs were appropriately supported, monitored and responded to .

Judgment: Compliant

Regulation 7: Positive behavioural support

While a number of clinical support systems for the management of behaviours were

implemented oversight and review of the use and effectiveness of these were not currently sufficient.

Staff did not consistently have the specific knowledge of the residents support plans or be able to implement them.

Judgment: Not compliant

Regulation 8: Protection

Overall there were improvements in recognition of abusive situations, however safeguarding plans required further details to guide staff and systems for review. The impact of behavioural incidents which occurred was not fully recognised in order to protect residents.

Judgment: Not 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 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
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Woodlands/Crossroads OSV-0001858

Inspection ID: MON-0024561

Date of inspection: 23/08/2018

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

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Management Oversight:
The organisation continues to actively recruit a CNM3. We have commissioned Hartley People Recruitment Company, Waterford to source this individual. This recruitment agency has 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.
Updated: 29th November 2018
• The organisation has 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.

Board Member:
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.

Updated: 29th 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.

Safeguarding Plans:
Safe guarding plans are now person centered specific to the residents needs and adequately guide staff in protecting residents who cannot protect themselves in some instances.
Safeguarding plans are being discussed at length with the staff supporting the residents.
Staff are required to sign off that they have read and understand the safeguarding plans.
Safeguarding plans have been discussed with the residents and will be further discussed at the MDT meetings.
The provider has implemented a framework for the management of statements made by residents which could be indicative of abusive interactions.

Updated: 29th November 2018
• Safeguarding plans were discussed at the MDT meetings and will be discussed at the scheduled MDT meetings to be held by end of December 2018.

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.

Updated: 29th 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, PIC and staff team

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.
Updated: 29th November 2018
• External auditors have carried out an unannounced inspection on this designated centre to provide a more objective review of this designated centre and the findings from this inspection will be actioned upon on receipt of the report within a specified time-frame.

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 commited to attending multidisciplinary reviews and they will occur annually or more frequently if required. These MDT meetings will review the overallhealth & 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.

The following actions have been taken:-

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:-
- The individual resident identified and discussed at the the HIQA exit meeting following inspection has had a DSAMT completed and this was carried out in collaboration with the resident and her family.
- The PIC of the designated centre has met with the resident and the family and has discussed and advised the family of the referral process.
- An MDT meeting took palce with this individual on 9th October 2018.
- This individual resident is being referred to the Executive Residential Committee at their planned monthly meeting end of October to establish if there is a suitable service to support and meet the needs of this individual. Should the DSMAT committee identify a suitable service provider, this provider will carry out an assessment to identify if they can support this individual. A decision of acceptance will be made by the individual and their family.
- At a meeting with the Disability Co-ordinator, HSE on 22nd October, the service was advised that an application will be made at the DSMAT meeting in October for funding to faciliate rolling respite between now and Christmas for this individual. This would involve approximately 6 nights between November & December. The respite facilities that are being considered at present are in the county. This is an interim measure for this individual to support their needs until a quality person centred service is identified for them.

Updated: 29th November 2018
• This interim plan for the identified resident is:-
Ongoing assessment for an appropriate respite service to meet her needs.
Two agencies have verbally confirmed that they will carry out an assessment in the new year for an appropriate placement in a residential setting to meet her needs.
• A definite plan is now in place to address the residents wellbeing which is being impacted on by the complex needs in this designated centre.

Residents future care:-
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 offerred to all residents.
It is planned that each resident in this designated centre will have an annual MDT meeting by end December 2018.
The purpose of this mapping exercise is to rewiew the compatability and complex needs of all residents residing within our residential services to identify if there is a more compatabile 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.

Updated: 29th November 2018
• A number of residents have had an MDT meeting and the mapping exercise was discussed at this with the residents and their family. This process will be completed by end of December 2018
• Planning permission has been sought for a new build to support the reduction in numbers in this desiganted centre and changing needs of the reside

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The recommendations made during the inspection was taken on board and amended in

the Statement of Purpose and submitted to HIQA on 14th September 2018. 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.

Regulation 26: Risk management procedures	Substantially Compliant

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

- In relation to the medications cabinet an office space will be built to reduce the risks in relation to the storage, safety and administration of medication.
- In relation to the personal alarm, all staff have been reminded of the directive given in relation to wearing a personal alarm when supporting an individual with behaviours that challenge. Following the feedback/exit meeting with the inspectors the identified person in the report no longer supports this individual.
- As incidents occur they will be reviewd and risks idenfied will be updated on the risk register.
- The remedial action section of the organisations Accident/Incident form will now record the deails of the actions and interventions required to reduce risks and their reoccurance.

Updated: 29th November 2018

- An office space has commenced and will be completed by 31st December 2018 to assist with the relocation and safety of the medication management press.
- As incidents occur they are being reviewed and risks identified are being updated on the risk register.
- The remedial action section of the organisations accident/incident form now includes the actions and interventions required to reduce risks and their re-occurance.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

While the residents had individual assessments from members of the multidisciplinary team a commitment has now been made by the newly appointed Disability Co-ordinator, HSE to facilitate a multidisciplinary review annually for each resident or more frequently if required. The Disability Co-ordinator HSE has committed to attending these meetings or a HSE representative will be present i.e. case manager & liaison nurse. At these meetings the interim and long term future needs of the residents will be discussed and

planned for ensuring the residents' needs and living arrangements are being met.

During unannounced inspections the provider will ensure that the outcome of MDT meetings and PCP meetings is being actioned on.

A definite plan is now in place to address the residents' wellbeing which is being impacted on by the different needs and behaviours in this designated centre as follows:-
Individual identified as critical:-
- The individual resident identified as critical at the exit HIQA meeting following inspection has had a DSAMT completed as discussed and requested by the HSE on 27th September 2018. This was carried out in collaboration with the resident and her family. The PIC of the designated centre has met with the resident and the family and has discussed and advised the family of the referral process.
- This individual resident is being referred to the Executive Residential Committee at their first available monthly meeting end of October to establish if there is a suitable service to meet the needs of this individual. Should there be a suitable service provider identified they will carry out an assessment on this individual and an offer of service will be made. The Executive Resdiential Committee will communicate in writing with the resident and family following the October meeting.
- In the interim, consent is being sought from the individual and the family to avail of a rolling respite servce while a suitable long-term service is being identified.
- A MDT meeting is scheduled to take place in relation to this individual 9th October 2018. This is the first of the MDT reviews that will occur for our residents. A planned schedule of MDT reviews will be put in place in collaboration with the HSE over the coming months.

Residents future care:-
- An identity profile/mapping exercise has been carried out on all the residents. The results of this profile will be 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 CEO and a member of the Board of Directors met with Wexford Co Council, Architect and the Builder on Thursday, 27th September. They have advised that the first phase of new houses has commenced and is planned to be completed in the next year. St. Aidan's will have a 5 bed purpose built bungalow in this phase. This house will provide a home for the older resident. St Aidan's is committed to providing a service to the end of life care of our residents.
- 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.
- A multidisciplinary review will take place annually for each resident or more frequently if required. The Disability Co-ordinator HSE has committed to attending these meetings or a HSE representative will be present i.e. case manager & liaison nurse. At these meetings the interim and long term future needs of the residents will be discussed and planned for.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- The PIC and senior management have ensured that all staff working in this designated centre are knowledgeable in relation to each residents needs and support plans.
- Staff are supervised during their practice to ensure that they are implementing the direction of the support plans. Staff must sign off that they have read and understand all support plans. This will ensure that this system will become embedded in practice.
- To ensure the effective oversight and review of support plans the following actions will be followed:-

- A referral will be made to the behaviour support team
- A referral will be made to the external Behaviour Support Specialist Clinic for review
- If any further actions are required, an MDT meeting will be scheduled which will involve the resident and family.
- In the event that the service can't meet the needs of the resident a referral will be made into the Executive Residential Committee (CHO5).
- Audits of phyical intervetion, the use of PRN medication for behaviours that challenge and pain mangement will now be recorded on the KPI template and will be monitered and reviewed by the PIC's and senior management for learning and quality improvement. The analysis of the findings will be discussed and shared at staff meetings.

Updated: 29th November 2018

• The Service Provider to schedule a review meeting with the external support specialist to discuss the current behaviour support plans and safety plans in relation to current pracices. Awaiting confirmation of date of meeting.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- Safeguarding plans have been reviewed to include further details to direct and guide staff.
- Staff will ensure that any resident exposed or impacted on from a behavioural incident will be supported and reassured. The impact of that behavioural incident will be recorded and reviewed, and if interventions are required, they will be put in place.
- Intimiate 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 integraty 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.

Updated: 29th November 2018

• An intimate care policy is now in place in this designated centre which will direct the practices of staff and further improve the safety, care and dignity of the residents.

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 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 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	Substantially Compliant	Yellow	31/12/2018

	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(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	31/12/2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	14/09/2018
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	09/10/2018
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	Not Compliant	Orange	09/10/2018

	needs or circumstances, which review shall be multidisciplinary.			
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	09/10/2018
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.	Not Compliant	Orange	24/08/2018
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/09/2018
Regulation 08(2)	The registered	Not Compliant	Orange	16/11/2018

	provider shall protect residents from all forms of abuse.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	30/09/2018
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Not Compliant	Yellow	16/11/2018