Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Iona House
Name of provider:	Praxis Care
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	09 August 2022
Centre ID:	OSV-0003415
Fieldwork ID:	MON-0037646

About the designated centre

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

Iona House provides full-time residential services to up to seven adults with an intellectual disability who may have associated physical disabilities. The centre is a purpose-built bungalow close to a nearby town, with easy access to all local amenities and shops. The service is staffed on a twenty-four-hour basis by a staff team up of the person in charge, team leaders, and support workers. Two residents are supported in individual self-contained apartments. The remaining residents are supported in the main part of the centre, with five single bedrooms including four with en-suite facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 9 August 2022	11:00hrs to 17:30hrs	Raymond Lynch	Lead
Tuesday 9 August 2022	11:00hrs to 17:30hrs	Anna Doyle	Support

What residents told us and what inspectors observed

This inspection was carried out due to concerns raised in relation to the health and safety of residents living in the centre. It is a statutory requirement for all providers to notify the Health Information and Quality Authority (HIQA) of any incidents which occur in their centre which may adversely effect residents. A number of notifications were recently submitted by this service reporting serious concerns related to the safety of care provided to the residents. After a review of these notifications HIQA made a decision to carry out this risk based inspection.

The inspection took place in a manner so as to comply with current public health guidelines and minimise potential risk to the residents and staff. The service provided residential care and support to seven adults with disabilities and comprised of a main house which supported five residents and two individual apartments to support the other two residents. It was in close proximity to local shops and other community based amenities and transport was available to residents for trips and social outings further afield.

The inspection found that while some good practice was observed, the governance and managerial oversight of the centre required review as the service provided was not safe nor appropriate to the assessed needs of the residents. Non compliances were found in governance and management, staffing, training and development, protection, risk management and residents rights. Following the inspection the provider was required to take urgent action and submit assurances that residents were safe and the issues identified on inspection were being addressed.

On arrival to the centre the inspectors met briefly with three residents who were preparing for a social outing with the support of staff. All residents smiled at the inspectors and appeared happy and content in their home. One resident said they were in good form and appeared enthusiastic regarding their day out.

Later in the day the inspector observed residents engaged in table top activities which they appeared to enjoy. Another resident was being supported on a 1:1 staffing basis and it was observed that they were getting their garden renovated. Over the course of the day staff were observed walking and chatting with this resident in the garden and the resident appeared happy and content in the presence of the staff member

Family visits were also supported and on the day of this inspection the inspectors observed one resident had a visit from a number of their relatives.

Later in the day one resident showed an inspector around parts of their home including their bedroom. The resident spoken with said they liked living in the house and spoke about going home to visit their family on a regular basis. A new kitchen had recently been installed in the centre and the resident said they liked this.

Another resident, who lived in an apartment on their own met an inspector briefly. They said they also liked living there however, they had a long term plan to move to their own apartment in the future. The resident spoke about some of their interests and activities they participated in.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

As stated previously this was a risk-based inspection carried out following receipt of a number of concerning notifications from the provider, which reported a number of allegations and raised serious concerns around some of the practices in the centre. Subsequent to the submission of those notifications and prior to the inspection in response to the concerns raised in the centre, the provider had commenced an investigation process and a took number steps to safeguard the residents.

However, at the time of this inspection, the inspectors found that this designated centre was not being effectively monitored and the governance arrangements were not adequate in ensuring the service provided was safe or appropriate to the assessed needs of the residents, Additionally, inspectors found there were gaps in staff training and ongoing issues in relation to the culture and practices in this service which were not being adequately addressed.

Such were the concerns as found on this inspection, the inspectors sought urgent assurances from the provider the day after the inspection in relation to the governance, management and staffing arrangements in place for this centre. A detailed response was submitted to HIQA by the provider, detailing the steps they immediately took after the inspection in order to improve the quality and safety of care provided to the residents. This response also detailed a number of additional steps and interventions the provider intended to take over the next three months so as to sustain those improvements.

According to the Statement of Purpose, the management structure in place in the centre was to consist of a person in charge (who worked on a full-time basis with the organisation) with the support of 4.5 team leaders. However, (and as identified via the services own auditing systems as far back as May 2022), there were a number of team lead vacancies which had been on-going prior to this inspection which was impacting on the supervision of staff and quality and safety of care delivered to the residents. Additionally, in monthly audits of the centre in June and July 2022, it was identified that there was a large turnover of staff in the centre and insufficient team leaders were available to provide adequate supervision of staff. This was concerning for a number of reasons.

For example, from speaking to staff working in the centre, inspectors found that

some of the medication practices were not in line with the provider's policies and were not safe. This was largely due to insufficient staffing levels/team lead support at night time in the centre. An inspector was informed that on some occasions, medication dispensed was not administered by the same person who dispensed it, which posed a risk, that incorrect medication could be administered to residents. While the person in charge said this was not standard practice, this issue required review as staff spoken with informed inspectors that this was the practice. Additionally, it was recorded on 04.08.2022 that due to staff shortages, one resident missed their 1pm medication and staff had to ring the GP for advice. This again posed a possible risk to the health of this resident.

The monthly audit in May 2022 also identified that there was a reduction in staff supervision due to the level of team lead vacancies in the centre. Again, this issue was of concern to the inspectors for a number of reasons. For example, from reviewing the minutes of staff meetings the inspectors observed that the person in charge and the head of operations had raised numerous concerns with staff around promoting the dignity of residents, maintaining appropriate records for residents and some staff attitudes in the centre. Additionally, a staff member had been reported for using inappropriate language in front of a resident. While these issues were raised with some staff, there was no clear plan available on how they would be addressed.

When the inspectors followed this up with the person in charge, they reported that the use of inappropriate language in the centre was happening prior to their commencement of work there. On review of the minutes of staff meetings and on review of the recent notifications submitted by this centre to HIQA, the inspectors were concerned that this type of culture had not been adequately addressed by management at the time of this inspection.

It was also identified that there were large gaps in mandatory staff training. For example, in March 2022 the auditing system identified that mandatory training was only at 32% for contracted staff and 28% for relief staff. In April 2022 mandatory training was as 56% and in May 2022 it was at 62%. Gaps were identified in fire safety training, infection prevention and control (IPC), positive behavioural support, restrictive practices and manual handling training. Considering the complex and significant needs of the residents living in this service the inspectors were concerned that at times, some staff did not have the adequate training (deemed mandatory by the service) to meet their assessed needs.

It was of concern to the inspectors that many of the issues identified in this report had already been identified by the management team in the centre and indeed, highlighted in various reports to include the auditing systems. However, they had not been adequately addressed. Taking the above into account and based on the cumulative findings in this report, the governance and management systems in place in this centre were ineffective in ensuring the service was safe, dignified or appropriate in meeting the assessed needs of the residents.

Regulation 15: Staffing

The staffing arrangements require review so as to ensure the numbers, skill mix of staff was all times appropriate and adequate in meeting the assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

The inspectors found that:

- there were a number of support worker vacancies at the time of this inspection
- there were a number of team-lead vacancies at the time of this inspection
- it was reported that there was a large turnover of staff in this centre
- the supervision of staff/supervision process required review.

All of this issues were impacting on the quality and safety of care provided to the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

There were large gaps in mandatory staff training for some staff. In March 2022 the auditing system identified that mandatory training was only at 32% for contracted staff and 28% for relief staff. In April 2022 mandatory training was as 56% and in May 2022 it was at 62%.

Considering the complex and significant needs of the residents living in this service the inspectors were concerned that at times, some staff did not have the adequate training (deemed mandatory by the service) to meet their assessed needs.

Gaps were identified in

- fire safety training
- infection prevention and control (IPC),
- positive behavioural support,
- restrictive practices and
- manual handling training.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and oversight systems in place were not adequate in ensuring the service was safe, dignified or appropriate in meeting the assessed needs of the residents for the following reasons:

- many of the issues identified in this report had already been identified by the management team in the centre and indeed highlighted in various reports to include the auditing systems however, they had not been adequately addressed
- staff practice in some instances
- mandatory training was not up to date
- staff supervision was not effective in ensuring issues were addressed or
- ongoing issues in relation to the culture and practices in this service which were not being adequately addressed to ensure residents were protected from any form of harm or abuse.

Judgment: Not compliant

Quality and safety

The process of risk management, safeguarding and residents rights required review so as to ensure the service delivered to the residents was at all times dignified, safe, appropriate and adequate in meeting their assessed needs.

There were systems in place to manage risk in the centre to include a risk management policy, a general risk register and a number of individual risk assessments on each residents file. However, this process required review as some of the risks in the centre were not being adequately managed and/or mitigated.

The provider had an emergency contingency plan in place which allowed for reduced staffing levels which were deemed acceptable and safe when some shifts could not be filled. The inspectors found however, that reduced staff levels in the centre were a regular occurrence and not based on emergency situations. Indeed, a review of staff rotas showed that there was insufficient staff in place to meet the needs of the residents in a safe manner on some days. This had not been adequately risk assessed and the inspectors found that at times when there were insufficient staffing levels, the service provided was not safe. For example, it was not clear how residents could be adequately supervised given the significance of their assessed needs. Some required 1:1 support, some required 2:1 support for personal care while others required increased supervision due to behaviours of concern and risks associated with falling. Staff also reported being 'exhausted' at times and raised concerns about their capacity to complete all cleaning tasks in the centre.

Additionally, a resident who had mobility and visual impairment issues had a fall in September 2021 and fractured their elbow. Their mobility plan identified they were

at a greater risk of falling due to issues related to their mobility and sight. In 2022 the resident had a further three falls resulting in bruising and a chipped elbow. However, the risk assessment for this person indicated they were at a low risk of falling despite all these incidences. While the person in charge had made a referral for this resident to be assessed by an occupational therapist in January 2022, this assessment had not taken place at the time of this inspection. Again, the inspectors were not assured that the risk assessment in place for this resident accurately reflected the level of risk they were exposed to and, the risks associated with falling were not being managed appropriately or safely.

The same resident presented with large bruising and scratching to their abdomen area/stomach on July 27, 2022. This was reported as a concern to the centre by staff working in the residents day activation unit. While the staff in the designated centre contacted the residents GP and relevant safeguarding teams about this issue, it was assumed that the cause of the injuries were due to self-injurious behaviour. Yet on further review, there were no records to verify this in the residents plans. For example, the resident's daily notes for the night of July 26, 2022 informed that they were vocal, very heightened, shouting for some time and banging doors throughout the night. However, the notes did not record any incidents of self injurious behaviour or indeed inform how the resident was reassured, supervised and safeguarded during this time.

Taking into account the multiple on-going concerns regarding this resident (falls, behaviours of concerns and disturbed sleep), there was inadequate information available as to how their bruising was investigated. This was concerning as the information on the incident form reported that some of the bruising looked old and this had not been investigated appropriately. In turn, the review process regarding the investigation of adverse incidents and for the management and supervision of behaviours of concern required review as it was unclear what learning took place on how to improve the quality and safety of care provided to the residents after such incidents.

Inspectors were also concerned that the rights of the residents were not being supported or promoted in this service. On reviewing the minutes of staff meetings inspectors found that each time there was a staff meeting, an issue was raised regarding residents care. For example, some concerns were raised about residents looking unkempt, their clothes not being ironed, their personal belongings been incorrectly stored, the use of inappropriate language in front of residents and negative attitudes around one resident.

Taking the above into account and the reflecting on the nature of some of the recent notifications of concern submitted to HIQA by this service, the systems in place to promote the rights and dignity of the residents and to safeguard them from all forms of abuse required review.

Regulation 26: Risk management procedures

The risk management process required complete review so as to ensure all risks in the centre were being identified and adequate control measures put in place so as to manage and mitigate such risks. In particular, risks associated with

- staff shortages
- falls
- behaviours of concern

These required review as the service was operating with a number of team lead vacancies and staff shortages at the time of this inspection and the contingency plans to manage these risks were ineffective in ensuring the service was safe or appropriate to the assessed needs of the residents

Additionally, one resident prone to falling sustained a number of injuries to include a broken arm and chipped elbow over the last 12 months. This resident was to be reviewed by an occupation therapist due to the risks associated with falling however, even though a referral had been made last January 2022, they had not been reviewed at the time of this inspection.

Judgment: Not compliant

Regulation 8: Protection

Taking into account the serious concerns as found on this inspection and on reviewing the nature of the recent notifications of concern submitted to HIQA from this centre, the systems in place to safeguard residents and protect them from all forms of abuse required review.

Additionally, the review process for the investigation of

- adverse incidents occurring in the centre required review and
- for the management of behaviours of concern

This was because it was unclear what learning took place on how to improve the quality and safety of care provided to the residents after such incidents .

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors were concerned that the rights and dignity of the residents were not being supported or promoted in this service. For example, at a number of staff meetings concerns were raised about the following

- residents clothes not being ironed
- residents looking unkempt
- residents personal belongings being incorrectly stored
- the use of inappropriate language in front of the residents
- negative attitudes around one of the residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Iona House OSV-0003415

Inspection ID: MON-0037646

Date of inspection: 09/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Registered Provider has assigned a Head of Operations / Clinical Nurse Lead as PIC to the Centre initially for 3 months, subject to review at this time. Commenced on 18.8.22 • The Registered provider has allocated an experienced PPIM to the Centre minimum 2 days per week for 3 months initially to support the PIC. Commenced on 18.8.22 • The Person in Charge / PPIM has ensured that the actual and planned rota is in place, showing staff on day and night duty and in line with the Statement of Purpose and assessed needs of residents. 11.8.22 • The Registered Provider has ensured all residents' needs have been re-assessed to ensure staffing / skill mix is in line with assessed needs. 11.8.22 • The Registered Provider will ensure that there are sufficient staffing levels at all times to respond appropriately to safeguarding risks in the Centre and ensure protection of residents. 11.8.22 • The Registered Provider can assure the Chief Inspector that the appropriate number, qualification and skill mix of staff is appropriate to the number and assessed needs of residents, the Statement of Purpose and the size and layout of the Designated Centre is in place. 11.8.22 • The Registered Provider has ensured that there is 1 team leader on duty 24 * 7 in the Centre, providing waking night duty cover. 11.8.22 • The Registered Provider will ensure that the following support worker shifts are met daily and at a minimum: o Main House: 8am-8pm 2 x Support Worker (During day service hours; 1 support	

worker)

o Apartment 1: 10am-10pm 1 x Support Worker (During day service hours; 0 support workers)

o Apartment 2: 1 x Support Worker 4pm – 10pm (6 hours per day)
Waking night x 1 support worker 8pm – 8am; Team Leader 24 * 7, waking night.

• The Registered Provider will ensure that active recruitment continues; As of 05.09.2022, there is 0.7 WTE team leader vacancy in the centre and 1 WTE support worker vacancy. The TL vacancy is filled by a competent temporary team leader. The current SW vacancy is filled by a consistent bank of relief and agency support workers who facilitate regular shifts. All vacancies to be filled by 30.11.2022

• The Registered Provider will ensure all staff receive meaningful monthly supervision for 6 months, at which point the regularity will be reduced to 2 monthly. These sessions will address record keeping, attitude and values and dignity. A HR Business Partner will attend 1 session per staff member.
o Commenced 15.8.22.

• The PPIM will review all supervision records to ensure supervision is effective in addressing any issues that arise and staff are supported to carry out their duties in an effective manner. Date 16.09.22

• The Registered Provider will ensure appropriate support and mentoring is provided to all staff and ensure that they are knowledgeable and skilled to meet the resident's needs.
o Commenced 10.8.22

• The PIC and PPIM will deliver workshops to all staff to ensure their development and understanding of needs assessment and support planning to meet service user needs effectively. 30.11.22

• The Registered Provider will ensure staff turnover in the centre is monitored through weekly meeting with HR and PIC. To be reviewed after 8 weeks.
o Commenced on 11.8.22
o To be reviewed on 11.11.22

Additional staffing has been agreed at MDT meeting 05.09.2022, 1:1 staffing agreed for one resident. This has been implemented with immediate effect. This will be reviewed in one month 05.10.2022.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The Registered Provider will ensure all outstanding mandatory training is completed as outlined :
• Fire Safety- 100% compliant 05/09/2022
• Infection Prevention- 100% Compliant 05/09/2022
• Positive Behaviour Support 100% compliant 30.08.2022
• Restrictive Practices: 100% compliant 30.08.2022
• Manual Handling: 100% compliant 02.08.2022
• Overall all mandatory training compliance as at 12.09.22 is 96%

• The Registered Provider has ensured face to face safeguarding of vulnerable adults at risk of abuse training is provided to all staff. 08/09/2022.

• The Registered Provider will ensure the Human Resource Department will hold workshops with all staff in relation to 'promoting a positive working culture' and 'understanding roles and responsibilities'. 21/10/2022

• The Registered Provider has planned bespoke Management of behaviour's workshops for all staff. To be completed by 28.10.22

• The Registered Provider has arranged for Incident Management training for all staff. 30.11.22

• The PIC and PPIM will deliver workshops to all staff to ensure their development and understanding of needs assessment and support planning to meet service user needs effectively. 30.11.22

• The Registered Provider has arranged for Report Writing training for all staff to be completed. 30.11.22

• The Registered Provider will ensure that all training deemed mandatory by the centre is monitored monthly through the training matrix and Head of Operations monthly monitoring report. Commenced 18.08.2022

• The Registered Provider will ensure all staff receive meaningful monthly supervision for 6 months, at which point the regularity will be reduced to 2 monthly. These sessions will address record keeping, attitude and values and dignity. A HR Business Partner will attend 1 session per staff member.
o Commenced 15.8.22.

• The PPIM will review all supervision records to ensure supervision is effective in addressing any issues that arise and staff are supported to carry out their duties in an effective manner. Date 16.09.22

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The Registered Provider will ensure that the staffing resource in the centre at all times is in line with the assessed needs of residents. 11.08.22

• The Registered Provider continues recruitment for :
o .7 WTE permanent team leader vacancies
o 1 WTE support worker vacancies
These vacancies are currently filled by consistent relief, temporary appointments and agency. 30.11.22

• The Registered Provider has assigned a Head of Operations / Clinical Nurse Lead as PIC to the Centre initially for 3 months, subject to review at this time. Commenced on 18.8.22

• The Registered provider has allocated an experienced PPIM to the Centre 2 days per week for 3 months initially to support the PIC. Commenced on 18.8.22

• Human Resources and the Person in Charge will meet weekly to progress any HR/recruitment matters. To be reviewed after 8 weeks.
o Commenced on 11.8.22
o To be reviewed on 11.11.22

• The Registered Provider will meet 2 weekly with the PIC, PPIM and Regional Director for a period of 3 months to review progress against required actions. 8.9.22

• An internal audit will be completed in October 2022 by the Quality & Governance Department. 31.10.22

• The Registered Provider will complete a Judgement Framework of the centre in September 22. 30.9.22

• The PIC will report to the PPIM two weekly for 3 months and the Regional Director will visit the centre monthly. 31.08.22
o Commenced 15.8.22.
o To be reviewed on 15.11.22.

• The Registered Provider will ensure that the Provider Nominee visits the Centre monthly for 3 months initially.
o Commenced 11.8.22.
o To be reviewed on 11.11.22.

• The Registered Provider has referred all residents to advocacy service and a meeting with advocacy has taken place in the centre on 07.09.22

• The Registered Provider has arranged MDT reviews for all residents, 2 meetings have taken place already and remaining have been scheduled. Completed the 05.09.2022 & to be completed 30.09.2022

• The Registered Provider has offered psychological support and intervention to some residents and their families directly impacted by a recent disclosure/allegation of concern. 11.8.22

• The Registered Provider will provide appropriate support and mentoring to all staff and ensure that they are knowledgeable and skilled to meet the resident's needs.
o Commenced 10.8.22

• The PIC and PPIM will deliver workshops to all staff to ensure their development and understanding of needs assessment and support planning to meet service user needs effectively. 30.11.22

• The Registered Provider will ensure all staff receive meaningful monthly supervision for 6 months, at which point the regularity will be reduced to 2 monthly. These sessions will address record keeping, attitude and values and dignity. A HR Business Partner will attend 1 session per staff member.
o Commenced 15.8.22.

• The PPIM will review all supervision records to ensure supervision is effective in addressing any issues that arise and staff are supported to carry out their duties in an effective manner. Date 16.09.22

• The Registered Provider has ensured that the review and application of medication procedures and assessed health care needs of service users will be overseen by the PIC whom is also the clinical nurse led. 10.8.22

• The PIC will ensure in line with policy all medication is dispensed and administered by the same person. 10.8.22

• The Registered Provider will complete monthly monitoring reports, undertaken by an experienced Operational Head. These will be reviewed monthly at supervision in totality in order to ensure timely management of any issues at all levels. 11.8.22

• The Provider Nominee will report weekly to Senior Leadership Team any safeguarding concerns to ensure appropriate management and oversight. Any trends will be reported monthly at the Operational Governance sub group meetings. These updates will also be shared with the Board of Praxis Care through the Care Committee. 10.8.22

• The Registered Provider will ensure that all training deemed mandatory by the centre is monitored monthly through the training matrix and Head of Operations monthly monitoring report. Commenced 18.08.2022

• The Registered Provider will ensure the Human Resource Department will hold workshops with all staff in relation to 'promoting a positive working culture' and 'understanding roles and responsibilities'. To be completed by 21/10/2022

• The Registered Provider will review monthly at the Operational Governance sub-Groups any red rated risks from the monthly management reports for the consequent months. 21.09.22

• The registered Provider will ensure that the Regional Directors of Care review each monthly monitoring report in totality and without exception. Commenced 12.09.2022

• The Registered Provider will ensure that the PPIM review all staff meeting minutes. To commence 20/09/2022

• The Registered Provider via our HR Department and Operational and Management, have interviewed all staff within the Centre in order to fully assess the culture. The HR Department/PPIM/PIC will ensure any actions culminating from same will be completed. 30.10.2022

• The Registered Provider will ensure the Human Resource Department will hold workshops with all staff in relation to 'promoting a positive working culture' and 'understanding roles and responsibilities'. To be completed by 21/10/2022

• Additional staffing has been agreed at MDT meeting 05.09.2022, 1:1 staffing agreed for one resident. This has been implemented with immediate effect. This will be reviewed in one month 05.10.2022.

• The Registered Provider has increased support in the centre from the Positive Behaviour Support consultants to review and monitor behaviours of concern in the centre, support staff and agree additional strategies to manage any risks. Commenced 10.08.2022

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Registered Provider will ensure that active recruitment continues; As of 05.09.2022, there is 0.7 WTE team leader vacancy in the centre and 1 WTE support worker vacancy. The TL vacancy is filled by a competent temporary team leader. The current SW vacancy is filled by a consistent bank of relief and agency support workers who facilitate regular shifts. All vacancies to be filled by 30.11.2022

• The Registered Provider can assure the Chief Inspector that the appropriate number, qualification and skill mix of staff is appropriate to the number and assessed needs of residents, the Statement of Purpose and the size and layout of the Designated Centre. 11.8.22

• The Person in Charge has ensured that one resident who is prone to falls has been reviewed by Occupational Therapy on the 02.09.2022. All recommendations brought to emergency MDT meeting 05.09.2022 and an action plan is in place. Review to occur in one month by the 05.10.2022

• The Person In Charge will update the residents risk assessment management plan in line with reviews and recommendation's by allied health professionals to ensure it accurately reflects the level of risk and those associated to falls. 05/09/2022

• Additional staffing has been agreed at MDT meeting 05.09.2022, 1:1 staffing agreed for one resident. This has been implemented with immediate effect. This will be reviewed in one month 05.10.2022.

• The Registered Provider has increased support in the centre from the Positive Behaviour Support consultants to review and monitor behaviours of concern in the centre, support staff and agree additional strategies to manage any risks. Commenced 10.08.2022

• The Registered Provider has planned bespoke Management of Behaviour's workshops for all staff. To be completed by 28.10.22

• The Registered Provider has referred residents to psychology and mental health intellectual disability team to provide support to those residents with behavioral needs. Commenced 18.08.2022

• The Person in Charge has updated the risk register to include all known risks in the Centre. Completed 06.09.2022

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Registered Provider has ensured face to face safeguarding of vulnerable adults at risk of abuse training is provided to all staff. To be completed by 08/09/2022.

• The Registered Provider will ensure that there are sufficient staffing levels at all times to respond appropriately to safeguarding risks in the Centre and ensure protection of residents. 11.8.22

• The Registered Provider will ensure all safeguarding concerns raised in the centre will be managed in line with the National Safeguarding policy. Commenced 18.08.2022

• The Registered Provider will ensure any actions or learning from incidents in the centre is taken forward by the Person In Charge and PPIM to improve the quality and safety of

care provided to residents. Commenced 05.09.2022

• The Registered Provider will ensure that all actions agreed in Formal safeguarding plans with the HSE safeguarding team will be implemented in centre. Commenced 05.09.2022

• The Registered provider will report weekly to Senior Leadership Team any safeguarding concerns to ensure appropriate management and oversight. Any trends will be reported monthly at the Operational Governance sub group meetings. These updates will also be shared with the Board of Praxis Care through the Care Committee. 10.8.22

• The Registered Provider has increased support in the centre from the Positive Behaviour Support consultants to review and monitor behaviours of concern in the centre, support staff and agree additional strategies to manage any risks. Commenced 10.08.2022

• The Registered Provider has planned bespoke Management of Behaviour's workshops for all staff. To be completed by 28.10.22

• The Registered Provider has arranged MDT reviews for all residents, 2 meetings have taken place already and remaining have been scheduled. Completed the 05.09.2022 & to be completed 30.09.2022

• The Registered Provider has arranged for Incident Management training for all staff. 30.11.22

• The Person in Charge will ensure that the National Safeguarding policy and safeguarding plans are discussed at monthly staff meetings and through staff supervision. Commenced on 15.08.22.

• The Registered Provider will ensure that where staff behaviour is not aligned to organisational attitudes and values, this will be managed and investigated appropriately to ensure residents rights and dignity are supported and promoted at all times. Commenced 18.08.2022

• The Registered Provider is engaged in a full investigation regarding the recent notifications of concern. The Registered Provider will ensure any actions/finding from this process are fully implemented. Commenced 2.8.22

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Registered Provider has referred all residents to advocacy service and a meeting with advocacy has taken place in the centre on 07.09.22

• The Person in Charge will ensure all staff complete human rights training. To be completed by 30.11.2022.

• The Registered Provider will ensure the Human Resource Department will hold workshops with all staff in relation to 'promoting a positive working culture' and 'understanding roles and responsibilities'. To be completed by 21/10/2022

• The Person in Charge will ensure Human rights, Restrictive practices & Safeguarding will be a fixed agenda item on all staff, Team Leader and Residents meetings. To Commence 01.09. 2022.

• The Person in Charge / Person Participating in Management will monitor resident's appearance and personal belongings are in line with assessed needs and policy and this will be reported on in the monthly monitoring report by the PPIM. Commenced 18.08.2022.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Red	11/08/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/11/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	16/09/2022

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	Red	11/08/2022
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	30/11/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/11/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of	Not Compliant	Orange	30/11/2022

	abuse.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/11/2022