Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Damara
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	26 February 2019
Centre ID:	OSV-0003446
Fieldwork ID:	MON-0024110

About the designated centre

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

Damara is a designated centre that provides residential support for both adults and children, male and female with intellectual disabilities. The centre is one building divided into three separate bungalows, each with their own front door and is located within walking distance of a busy city. Children's accommodation is provided separately to adults. The staff team consists of nurses, social care workers and healthcare assistants. The residents supported in Damara present with many complex needs and avail of additional supports including physiotherapy, occupational therapy, nutritional support and support attending external medical appointments. The home is a seven day residence open all year with no closures. There are seven people supported in Damara and the centre has the capacity for eight people. Damara has three service vehicles available for residents use.

The following information outlines some additional data on this centre.

Current registration end date:	14/05/2021
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 - 2015 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
26 February 2019	08:30hrs to 16:30hrs	Laura O'Sullivan	Lead
26 February 2019	08:30hrs to 16:30hrs	Sinead Whitely	Support

Views of people who use the service

There were seven residents living in the designated centre on the day of inspection with one vacancy.

The inspectors met with 3 number of residents over the course of this inspection. Residents used non verbal methods to communicate. The views of residents were therefore primarily based on inspectors interactions and observations over the course of this unannounced inspection. No specific resident expressed any complaint in their interactions with inspectors over the course of the day.

Inspectors observed and listened to residents going about their daily morning routines. The environment was observed to be quite loud with doors banging, staff talking and music loudly playing. This environment was contradictory to individual support plans in place, highlighting the importance of low-arousal environments for residents living in the designated centre.

Capacity and capability

The inspectors reviewed the capacity and capability of the designated centre and overall, the inspectors found significant improvements were required to ensure a safe and quality service was delivered to the residents living in the designated centre. Concerns identified on the previous inspection had not been adequately addressed by the registered provider.

The registered provider had appointed a person in charge of the designated centre. This post was full time and the person nominated had the necessary qualifications, skills and experience required by the regulation. This person was appointed to the position two and a half months previous to the inspection date. It was identified that while this person was endeavouring to provide a quality service, a higher level of oversight and monitoring of the designated centre was needed to ensure an effective service was being provided to all aspects of the centre. A number of duties had been delegated to the team leader appointed to the centre, however the person in charge did not demonstrate management and oversight to ensure completion of these duties.

The registered provider had ensured there was a clearly defined management structure in place in the designated centre that identified lines of authority and accountability. A person nominated by the registered provider completed six monthly unannounced visits to the designated centre and carried out audits

which identified areas in need of improvement. These audits did not effectively identify all areas in need of improvement. Particularly in relation to safeguarding procedures, safeguarding measures and safeguarding plans in place. This was discussed at length on the day of inspection with members of the organisational governance team. Furthermore, the annual review did not have any input from resident and/or their representatives and again did not identify issues in relation to safeguarding. The monitoring systems in place were not utilised to ascertain the residents satisfaction in the service provided or if residents felt safe.

The person in charge had ensured staff had received mandatory training on the day of inspection. This included training in safeguarding, fire safety, children's first and manual handling. However, not all staff had received up-to-date refresher training, with four staff members identified as outstanding on parts of their refresher fire safety training. Furthermore, five staff members had not received training in the management of challenging behaviours. This was necessary to meet the specific care needs of a number of residents and to ensure their safety. Formal supervision of staff required review. Documentation reviewed evidenced limited information of topics discussed and actions set out should a staff member raise a concern.

The inspectors reviewed a number of residents daily reports, a sample of the centres accident and incident log, and a number of trust in care records and found that incidents were not notified to the Office of the Chief Inspector as required and within the allocated time frame. These included allegations of suspected or confirmed abuse of any resident and any allegation of misconduct by staff. One resident had recently sustained an injury which required medical review and this also had not been notified in accordance with regulatory requirements.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge of the designated centre. This post was full time and the person nominated had the necessary qualifications, skills and experience required by the regulation. The person in charge however, did not have oversight of all aspects of the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff had received mandatory training on the day of inspection. This included training in safeguarding, fire safety, children's first and manual handling. However, not all staff had received up-to-date refresher training

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place in the designated centre that identified lines of authority and accountability. Regular audits of the service were being carried out, however these were not effectively identifying areas in need of improvement. Furthermore, these did not always include input from residents or their representatives.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed a number of residents daily reports, a sample of the centres accident and incident log, and a number of trust in care records and found that not all notifiable adverse incidents were notified to the Office of the Chief Inspector. These included allegations of suspected or confirmed abuse of any resident and any allegation of misconduct by the registered provider or by staff.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the registered provider, person in charge and people participating in management were endeavouring to provide a quality service to the residents living there. However, significant improvements were needed in relation to the safeguarding and protection of the residents living there. Due to the concerns which arose on the day on inspection the registered provider was issued with an urgent action with respect to protection and safeguarding procedures and practices, to ensure the safety and well being of all residents. Assurances were received in the compliance plan response to the urgent action setting out the actions the provider was planning to take to ensure all residents were appropriately safeguarded.

Significant safeguarding concerns were identified on the day of inspection. All staff had received up-to-date training in the safeguarding and protection of vulnerable adults and children's first. However, training did not appear to be guiding safe practice at times. An organisational safeguarding policy was in place, this did not appear to be effectively guiding staff practice at times following an allegation of

abuse. On a number of occasions staff members did not notify the senior staff on duty for a significant length of time. When an alleged abusive situation was witnessed adherence to local and national policy was not evident.

In reviewing a number of safeguarding investigations, inspectors found a sub standard investigative process regarding the reporting, recording, preliminary screening, safeguarding planning and procedures followed. When brought to the providers attention by inspectors, a representative of the organisation acknowledged that they were not satisfied or assured by the outcome of a number of these investigations. As part of assurances received this concern was to be addressed.

Prior to this inspection, two notifications of alleged abusive where received by HIQA. As a result, the registered provider had been issued with a provider assurance report, to give assurance to HIQA that appropriate safeguarding measures were in place. However, on further review of this matter on inspection, a number of actions which had been reported as complete, had not been implemented. For example, a safeguarding plan and risk assessment had not been developed and completed as was assured. Safeguarding concerns and reporting systems were not discussed in team meetings according to meeting minutes reviewed. In addition, inspectors were not assured that all staff members were aware of current control measures to reduce the risk to the residents.

The inspectors observed a safeguarding plan which had been put in place following an identified alleged safeguarding issue, the plan in place did not effectively mitigate the chance of an incident re-occurring. Also safeguarding plans, where present did not clearly set out what the safeguarding concern was and why safeguarding plans were in place. Inspectors could not obtain evidence that staff members were aware of safeguarding measures which had been out in place therefore adherence to same was not clear. There was not evidence that safeguarding plans were regularly reviewed and closed should the safeguarding concern be mitigated.

Following this inspection the provider highlighted that all of these safeguarding issues would be thoroughly reviewed and amended as a matter of priority.

Regulation 8: Protection

The registered provider had not ensured that effective measures and safeguarding systems were in place to protect residents from all forms of abuse.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 8: Protection	Not compliant

Compliance Plan for Damara OSV-0003446

Inspection ID: MON-0024110

Date of inspection: 26/02/2019

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 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:
A qualified and experienced PIC has been assigned to the designated centre full time in December 2018.
A Team Leader is supporting the PIC within the designated centre to ensure the day to day operational management and supervision of staff.
The PIC is supported by the Community Service Manager (CSM) within the cluster model.
Quality conversations are scheduled between the CSM, the PIC and the Team Leader on a 6 weekly basis.
Monthly '3-way-meetings' between the CSM, PIC and Team Leader are scheduled to ensure delegated duties and actions are discussed, documented and followed up.

As a result of the inspection an emergency action plan meeting was held on the 27/03/2019 between the Director of Service, CSM, PIC, TL and Quality Department to discuss immediate actions regarding Regulation 8 'Protection' but also to identify support needs for the PIC regarding management and oversight in Damara.

The CSM and PIC have developed a 'Management oversight schedule' to support the PIC in her protected time for management and oversight work within the designated centre.

Following actions are part of the 'Management oversight schedule':
• To ensure better oversight the PIC located her office in Damara No 2.
• Weekly oversight meetings between the PIC and Team Leader are scheduled to discuss progress and actions regarding Damara No 1.
• The PIC and Team Leader are working on opposite shifts to ensure oversight and governance the designated centre Damara. A daily handover between PIC and Team Leader ensures information is passed on immediately.
• The PIC is requesting weekly reports of the Team Leader and the 2 nurses in Damara regarding progress on actions and outstanding issues.
• The PIC has delegated Quality Conversations for staff in Damara No 1 to the Team

Leader and in Damara No 3 to the staff nurse. The PIC will attend Quality Conversations as necessary.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Employees are supported to attend mandatory and mandated training/courses. It is also the responsibility of employees to propose training that would enhance and support their role within St. Patrick's Centre (Kilkenny).

A centre specific training profile, individual employee training profiles and a training schedule are distributed monthly to the PIC and CSM of the centre by the Training Department. Employee training is on the agenda of the monthly team meetings.

The PIC and Team Leader have staff booked in for the following training:
• Refresher Fire Training Level 2 on the 12/04/2019
• Keyworker Training on the 18/04/2019
• Studio 3 (Managing challenging behaviours) on the 10 – 12/04/2019

The PIC has a schedule for the 6 weekly Quality Conversations with the employees in the designated centre in place to ensure continuous development.
The Quality Conversations policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for employees. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

As a result of the emergency action plan meeting on the 27/03/2019 the Director of Service and the HR manager decided to deliver Supervision training for all management staff within St. Patrick's Centre (Kilkenny). This will ensure Quality Conversations are completed and documented as set out in the QC Policy. This training will be rolled out in April 2019.

Regulation 23: Governance and management	Not Compliant

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

There is a clearly defined management structure in the designated centre that identifies the lines of authority, accountability, specific roles and also details of responsibility for all areas of service provision.

As part of the action plan meetings after the risk inspection the management systems in the designated centre were discussed and reviewed to ensure the service provided is safe, appropriate to the people supported needs and ensures consistent and effective monitoring.

The CSM and PIC have developed a 'Management oversight schedule' to support the PIC in her protected time for management and oversight work within the designated centre.

Following actions are part of the 'Management oversight schedule':
• To ensure better oversight the PIC located her office in Damara No 2.
• Weekly oversight meetings between the PIC and Team Leader are scheduled to discuss progress and actions regarding Damara No 1.
• The PIC and Team Leader are working on opposite shifts to ensure oversight and governance the designated centre Damara. A daily handover between PIC and Team Leader ensures information is passed on immediately.
• The PIC is requesting weekly reports of the Team Leader and the 2 nurses in Damara regarding progress on actions and outstanding issues.
• The PIC has delegated Quality Conversations for staff in Damara No 1 to the Team Leader and in Damara No 3 to the staff nurse. The PIC will attend Quality Conversations as necessary.

St. Patrick's Centre (Kilkenny) audit schedule is in place and used to monitor optimal quality of services to the people we support. This schedule is available in the centre to guide the auditing process.
The PIC and Team Leader will carry out in-house audits as per audit schedule and will monitor all aspects of care provided to the person supported. These audits will create action plans and delegated duties for the staff team.

An annual provider audit was completed in July 2018. A 6 monthly provider audit was carried in the designated centre and is completed by the 05/04/2019. The CSM, PIC and Team Leader are discussing the action plan in the 3 way meeting to ensure all issues are addressed.

To ensure that provider audits are completed in line with the regulations the Director of Service has scheduled training on the 04/04/2019 for the Community Service Managers, Project Officers and the Quality Department. This training will facilitate knowledge transfer between staff who is completing provider audits and build capacity to ensure provider audits are completed in line with the regulations and include input from people supported and/or representatives.

A customer satisfaction survey has been developed within St. Patrick's Centre (Kilkenny). Due to some necessary changes on the survey it has not been distributed as planned for the 17/03/2019. The link to the survey was circulated to all people supported and their Team Leaders on the 01/04/2019 via email. The Team Leaders will ensure that keyworkers are supporting the people to complete the survey.

The survey will also be distributed to the representatives of all people supported and staff on 01/05/2019.

Going forward St. Patrick's Centre (Kilkenny) will distribute the customer satisfaction survey every year on the 1st April to all people supported, their representatives and staff.

The PIC and Team Leader are introducing the Questionnaire for residents (HIQA guidance document) on the 06/04/2019 to support staff and people supported in team and residents meetings to ensure people supported's voice about the service being provided is captured.

Effective arrangements are in place to support, develop and performance manage all members of the workforce. Within Quality Conversations any issues of performance are identified, recorded and communicated with staff and plans are put in place to build capacity (e.g. training, coaching, action analysis). The PIC has a scheduled monthly meeting with his HR Partner to discuss all performance management issues.

To ensure all management staff has the necessary skills to provide Quality Conversations of high standard, the HR Manager is in the process of developing Supervision training for all management staff within St. Patrick's Centre (Kilkenny). This training for behavioural competences/quality conversations will be rolled out for all management staff during the month of April 2019.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All notifiable incidents were notified to the Office of the Chief Inspector immediately after the inspection took place.

The registered provider has taken immediate action after the risk inspection to review processes within the service regarding the notification of incidents. The internal notification and communication processes regarding incidents within St. Patrick's Centre (Kilkenny) were reviewed and clarified. The electronic incident report system (DMS) has been updated.

The registered provider is rolling out HIQA Portal training since the 06/03/2019 for all CSM's and PIC's within the service to ensure notifications are completed in line with the regulations.

The CSM, PIC and Team Leader ensured immediately after the risk inspection through Team meetings and Quality Conversations that support staff in the designated centre Damara are aware of the processes around notifications of incidents.

The PIC has scheduled training with the social worker on the 03/04/2019 for all staff in the designated centre to ensure knowledge and awareness around incidents within the support staff team.
The social worker was also building capacity with each keyworker in the designated centre regarding the completion and review of safeguarding plans in relation to incidents.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Response with regard to ensuring the registered provider is protecting residents from all forms of abuse:
The registered provider has taken immediate action after the risk inspection on the 26/02/2019 to implement learning from the non-compliances.

1. The Senior Management Team has reviewed the safeguarding pathway and communications structure within SPC in a meeting on the 27/02/2019.To ensure that SPC is fully compliant with the National Safeguarding Policy and implementing the learning from the risk inspection, new systems will be initiated as follows;
• An Oversight Safeguarding Committee has been established – consisting of senior management team members and designated safeguarding officers. Terms of References (TOR) for this committee are in the process of being completed by the Senior Safeguarding Officer and will be available on the 04/03/2019.
• Clarification on notification to the Gardaí (AGS) in this specific case was discussed and the notification process to (AGS) implemented, as part of the Safeguarding process as per National Safeguarding Policy.
• The internal notification and communication processes regarding incidents within SPC were reviewed and clarified.

2. The electronic incident reporting system (DMS) was updated to include the following;
• When completing an incident report, an automatic control measure is now in place to trigger the necessary HIQA notification (e.g. NF06 or NF07) which will only be completed by the PIC.
• A log of internal notifications and TIC processes is available for all senior management.
• A drop down box will be implemented on the incident report form regarding notification to AGS, thus ensuring that this is considered and rationale provided for decided outcome.

3. SPC has 10 Designated Safeguarding Officers within the Service. A list of these officers and contact details will be published across the services, to ensure every employee, knows whom to contact, in the event of an incident and to ensure notifications are completed in a timely manner.

4. To ensure that SPC has a robust policy for safeguarding in place, a review of the current safeguarding policy is being processed to implement all learning from the

feedback of this inspector. The review and implementation of learning will be completed by 29/03/2019.
This review will be completed in tandem with a review of the electronic incident reporting system (DMS). An internal SPC easy read flow chart will then be available so as to depict visually the process of safeguarding within the service.

5. An emergency action plan meeting was held on the 27/02/2019 at 8:30am between the Director of Service, Community Service Manager, the PIC and the Quality Department to discuss the learning of the risk inspection, implement immediate actions and responsibilities to ensure the people supported are safe and protected from abuse.

6. The Director of Services met on the 27/2/2019 at 9:00 am with the HR department to review the learning from the risk inspection and also discuss strategies around the management of staff / immediate actions / support after allegations of abuse being made.
This will be a priority piece of work for the new HR / IR manager, who is commencing employment with SPC on the 04/03/2019. An update on actions in progress of the new strategies around management of staff after alleged abuse incidents will be given to the Inspector on 30/03/2019.

7. The registered provider recognises the importance of Supervision of staff as an integral component of the safeguarding process. The new HR / IR manager will be 'rolling out' Supervision training within the service, so as to build capacity around supervision of staff for all Line and Clinical managers. This will be a priority pillar of her responsibility.

8. The registered provider recognised the weaknesses in risk assessments to safeguard people supported. The registered provider also acknowledges that safeguarding plans were not sufficiently robust to ensure guidance for staff to ensure the safety and welfare of the people supported. The registered provider will ensure that risk assessments for all people supported, that experienced abuse, are completed and safeguarding plans will be comprehensive and focused on the person supported needs.

9. A meeting was held between the Community Service Manager, the PIC, the Social Work and Quality Department on the 27/02/2019 at 11am to discuss the safeguarding processes and capacity building not only within this designated centre but across the entirety of SPC.

10. The registered provider also acknowledges the importance of safeguarding at any level of the organisation. Key learning from the risk inspection will be delivered throughout the service via line management.

• A Senior Management Team Meeting was held on 27/02/2019 at 2:30pm to discuss the review of the Safeguarding Pathway within the service.
• Key learning from the risk inspection and outcomes from the meetings on the 27/02/2019 has been delivered by the Director of Services during a mandatory attendance Change Management meeting on the 28/02/2019.

11. The registered provider also acknowledges the importance of Annual and 6

monthly provider audits to safeguard people supported within the service. To ensure good governance is available throughout the service a meeting is scheduled 04/03/2019 to discuss the completion of provider audits and ensure capacity building. The Operations Manager, Director of Service, the Community Service Managers, Quality Department and Quality Project Officers will attend this meeting.

12. As part of the learning from the risk inspection, the registered provider is supporting the development of a customer satisfaction survey. This Easy Read document will be circulated on the 17/03/2019 to all people supported, their families and the PIC's.

13. To ensure compliance within Regulation 8(3), the Community Service Manager and PIC of the designated centre reviewed all recorded incidents to ensure notification to HIQA as per regulations.

14. Guidance will be sought from the new HR / IR manager regarding possible review of a TIC process, which was completed for a staff member in the designated centre. Any actions arising therefrom, will guide further actions for the registered provider.

15. To ensure learning from the risk inspection is cascaded within the services, all PIC's are reviewing their incidents to ensure notifications from other centres are completed if necessary.

16. Specific to the incidents reviewed in the designated centre, the following actions have been taken to ensure the person supported is safe and protected from abuse:
• The person supported is supported, reassured and monitored by support staff, the TL and PIC.
• A clinical review was undertaken by the nurse.
• The person supported has been referred to the Clinical Supervision Specialist.
• A risk assessment is in place for the person supported to protect him from abuse.
• A risk assessment will also be completed for all people supported in the designated centre.
• The PIC has booked identified staff for mandatory training as required.
• The alleged perpetrator / staff member has been relocated to another designated centre with senior supervision (staff nurse or SCW) at all times.
• The PIC and CSM for that designated centre have been informed.
• The PIC in the new centre will carry out an induction for the staff member and will conduct weekly Quality Conversations.
• A risk assessment and supervision guidelines will be completed by the PIC of this designated centre and the staff team informed about the move.
• The supervision guidelines will be reviewed once the TIC process is concluded.
• The TIC Preliminary Screening has been completed and sent back to the commissioner for review.

17. The registered provider will ensure all actions are being carried out by the identified responsible people.
• A follow up meeting on all actions agreed in the meetings from the 27/02/2019 will take place on the 07/03/2019 at 2pm and will be attended by the DOS, PIC, CSM and Quality coordinator.
• A weekly review of progress on actions of the compliance issues, will take place

between the Director of Service, CSM, PIC and Quality Department over the next month.

Please find the following update regarding the actions taken since 01/03/2019 as mentioned above:

• Follow up action plan meetings were held between the Director of Service, CSM, PIC, Team Leader and Quality Department on the 07/03/2019 and 20/03/2019 to ensure actions are being discussed and followed through.
• At a meeting on the 21/03/2019 the HIQA compliance plan response was discussed with the PIC and Team Leader.
• The Safeguarding Protection and Oversight Committee has been implemented. The Terms of References are completed and the Committee has scheduled a first meeting on the 16/05/2019.
• The SPC Safeguarding poster was updated with a list of all designated officers and is now available in all designated centres.
• The registered provider is reviewing the strategy/policy around management of staff after alleged abuse incidents. The Director of Service and the HR Manager discussed to put staff on paid leave after an allegation of abuse/safeguarding being made against staff. The policy is currently under review. The amended policy will be completed by 30/04/2019 to be then discussed with the Unions.
• A customer satisfaction survey has been developed. Due to some necessary changes on the survey it has not been distributed as planned for the 17/03/2019. The link to the survey was circulated to all people supported and their Team Leaders on the 01/04/2019 via email. The Team Leaders will ensure that keyworkers are supporting the people to complete the survey. The survey will also be distributed to the representatives of all people supported and staff on the 01/05/2019

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	05/04/2019
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.	Substantially Compliant	Yellow	18/04/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	30/04/2019

	are appropriately supervised.			
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	05/04/2019
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	01/05/2019
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 quality of care and support provided in the centre and put a plan in place to address any concerns regarding	Not Compliant	Orange	05/04/2019

	the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	05/04/2019
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Substantially Compliant	Yellow	08/03/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of	Not Compliant	Orange	08/03/2019

	abuse of any resident.			
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.	Not Compliant	Orange	08/03/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	26/02/2019
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	26/02/2019
Regulation 08(4)	Where the person in charge is the subject of an incident, allegation or suspicion of abuse, the registered provider shall investigate the matter or nominate a third party who is suitable to investigate the matter.	Substantially Compliant	Yellow	30/03/2019
Regulation 08(7)	The person in	Substantially	Yellow	03/04/2019

	charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Compliant		