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 (Adults)

Name of designated centre:	Teach Solas/Oaklands
Name of provider:	Health Service Executive
Address of centre:	Longford
Type of inspection:	Unannounced
Date of inspection:	17 May 2019
Centre ID:	OSV-0003761
Fieldwork ID:	MON-0023370

About the designated centre

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

Teach Solais/Oaklands is a designated centre in a large town in Co. Longford. It comprises of two large community homes, located a short distance from each other. One house is a five bedroom bungalow and the other is a four bedroom dormer style bungalow. Each resident has their own bedroom which has been personalised to their own individual styles. Two of the bedrooms in each house are en-suite. The houses are spacious and have adequate communal space for residents. Some adaptations have been made in the homes to meet the needs of residents who have mobility issues. Both houses have gardens to the back of the properties. Transport is provided should residents wish to avail of it for leisure activities and appointments.
The centre provides fulltime residential care to nine male and female adults, some of whom require support around their emotional well-being and healthcare needs.
The centre is nursing led, meaning that a nurse is on duty 24 hours a day. Health care assistants and social care workers are also employed to support residents.
Some residents do not attend formal day services. They are supported by staff in the centre to having meaningful activities during the day in line with their personal preferences.
The person in charge is fulltime in the centre and is also supported by a clinic nurse manager 1 to ensure effective oversight of the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
17 May 2019	09:00hrs to 18:30hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

The inspector met all of the residents in the centre. Some of them met with the inspector with the support of staff to assist the inspector with the residents' communication preferences. One resident sang a song they had made up with staff about their love of shopping. They spoke about some of their activities in the centre. This included using an exercise bike, shopping and going out for coffee.

Residents were engaged in activities during the day. In one of the community homes, two residents were going to an activity centre for the morning and two were being supported by staff to engage in activities of their choice.

Communication aids were in place to support residents for example; menu options were in picture format to enable residents to make choices. The staff who were on duty for the day were presented in picture format to inform residents (who liked routine and familiar staff).

Residents were observed to be comfortable in the presence of staff. Staff responded to residents' needs in a timely manner and it was evident that they knew the residents' needs well. For example; the inspector observed staff offering immediate assurances to a resident who found loud noises very difficult on the day of the inspection.

Capacity and capability

Overall while some positive outcomes were observed for residents in the centre, a number of the regulations inspected required significant improvements to ensure a safe and effective service for residents.

The inspector found that the governance and management arrangements in the centre required improvement. Improvements (some of which had already been identified by the provider) included insufficient staffing arrangements in one area, compatibility issues, fire safety, premises, risk management and positive behaviour support.

There was a clearly defined management structure in the centre. The provider had made appropriate arrangements for the position of person in charge which is a key management position in the centre. The person in charge was full time in the centre. They were a qualified nurse, with considerable years of experience working

in the area of disability. They were also supported by a clinic nurse manager 1(CNM1) who had only recently been appointed in the centre. A staff nurse on duty during the day and at night was assigned as the shift leader to oversee care practices. An out of hours on call service was also provided by senior nurse managers in order to support staff.

The person in charge (PIC) reported directly to an assistant director of nursing (ADON) who in turn reported to the director of nursing. Staff said that they reported concerns to the PIC or the CNM1.

However, the management systems were not ensuring that the services provided were safe, appropriate to the residents' needs or consistently and effectively monitored. For example; areas of improvement highlighted by the provider in their Annual Review (dated September 2018) for the centre had not progressed at the time of this inspection. And there was no clear plan about how they would be addressed. These actions included sourcing a more suitable living arrangement for one resident, painting one of the community homes and providing a sensory room for residents in one of the community homes.

It was also not evident who was accountable to ensure how areas of improvement were progressing as the person in charge and their manager did not formally record their meetings in order to assure how areas were being addressed. For example; the inspector was informed that some areas of improvement could not be resolved due to resource issues however there were no records to support this.

A copy of the last unannounced quality and safety review of the centre was available in the centre. This was dated September 2018. The inspector reviewed a sample of the actions outlined from this and found that they had been addressed by the person in charge and staff. For example; a fire drill needed to be completed and this had been done. However, at the time of the inspection the provider had not conducted a further quality and safety review as required every six months under the regulations.

While some improvements were required effective oversight was being maintained through the carrying out of audits in areas such as residents' personal finances and personal plans.

There was adequate staff in place to support residents living in one community home. A review had also taken since the last inspection which included increasing the staff numbers on duty in this community home.

However, the staffing arrangements in the other home required review in order to meet the social care needs of the residents every day. For example; two residents had been identified as requiring 1:1 support and there was only 2 staff on duty some days with five residents. As a result on some days residents could not avail of activities outside the centre and if they did, they may be required to return early so as staff could assist with other residents needs in the centre. The inspector also found that this was impacting on one resident's behaviours of concern in the centre as it was highlighted in their risk assessment dated January 2019 that having

meaningful activities during the day, helped to reduce the resident's anxiety.

While the inspector acknowledges that a business case had been prepared and submitted to senior managers outlining these concerns there had been no progress at the time of the inspection as to how this would be addressed.

The inspector also found that there was a reliance on agency staff as there were four staff vacancies in the centre. While a consistent agency panel was employed, this reliance was impacting on service provision as there were a number of complaints raised on behalf of residents when there were staff shortages due to no relief or agency staff being available to cover shifts.

The provider was in the process of taking some proactive steps to address the staffing resource. The person in charge informed the inspector that some new staff had been recruited to fill the current vacancies. Induction processes were also in place for new staff in the centre. For example; on the day of the inspection one new staff was shadowing other staff to ensure they were aware of the needs of the residents.

Of the staff met they were knowledgeable around the residents' needs in the centre. They said they felt supported by the person in charge were able to raise concerns about the quality of services in the centre at any time, and through supervision and staff meetings which were held regularly. One staff gave an example of how their concerns were addressed when they raised a concern about staffing levels in the centre.

From a review of the training matrix, all staff had completed mandatory training in safeguarding vulnerable adults, fire safety and manual handling. Other mandatory training required by the provider had also been completed by all staff. This included CPR, positive behaviour support, the management of epilepsy and infection control. However, there were a number of gaps in the training records for other training that was to be provided to staff some of which related to autism awareness, dementia and the use of some transport equipment in the centre.

There were systems in place to record and respond to any complaints arising in the service. This included a logging system to record complaints, which included the nature of the complaint, how it would be addressed and if it was addressed to the satisfaction of the complainant. However, it was not always clear how it was addressed or if the complainant was satisfied with the outcome. For example; staff had logged complaints on behalf of residents in relation to staffing in the centre. It was not demonstrated how this had been followed up with the resident or whether they were satisfied with the outcome.

It was also observed that residents had access to independent advocacy services. Staff also advocated on behalf of the residents in relation to staffing arrangements and providing more individualised supports for some of the residents. This showed that the residents were being facilitated to make their views known.

Regulation 14: Persons in charge

The inspector found that there was a person in charge in the centre, who was a qualified nurse with significant experience of working in and managing services for people with disabilities.

They were also aware of their remit under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangements in one community home required review in order ensure that they met the social care needs of the residents every day.

There was a reliance on agency staff in the centre as there were four staff vacancies in the centre which at times was impacting on the delivery of services to residents.

Staff personnel files were not reviewed as part of this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Of the staff met they were knowledgeable around the residents needs in the centre. They felt supported by the person in charge and had supervision and regular staff meetings were held in the centre. Staff said they were able to raise concerns about the quality of services in the centre.

From a review of the training matrix, all staff had completed mandatory training in safeguarding vulnerable adults, fire safety and manual handling. Other mandatory training required by the provider had also been completed by all staff this included

CPR, positive behaviour support, the management of epilepsy and infection control.

However, there were a number of gaps in the training records for other training that was to be provided to staff, some of which included, autism awareness, dementia and the use of some transport equipment in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems were not ensuring that the services provided were safe, appropriate to the residents' needs or consistently and effectively monitored. For example; areas of improvement highlighted by the provider in their Annual Review (dated September 2018) for the centre had not progressed at the time of this inspection.

The provider had not conducted an unannounced quality and safety review of the centre every six months as required under the regulations.

It was not evident who was accountable to ensure how areas of improvement were progressing.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge was aware of their remit to notify the Chief Inspector, as required by the regulations, of any adverse incidents occurring in the centre.

Judgment: Compliant

Regulation 34: Complaints procedure

There were systems in place to record and respond to any complaints arising in the service. This included a logging system to record complaints, which included the nature of the complaint, how it would be addressed and if it was addressed to the satisfaction of the complainant. However, it was not always clearly recorded how it was addressed or if the complainant was satisfied with the outcome.

Residents had access to independent advocacy services. Staff also advocated on behalf of the residents in relation to staffing arrangements and advocated for more individualised supports for some of the residents.

Judgment: Substantially compliant

Quality and safety

Overall the inspector found that staff were providing person centred care to the residents as much as possible given the constraints identified in part one of this report. Notwithstanding this, significant improvements were required to ensure that the arrangements in place to ensure residents were safe were monitored and reviewed.

The were many positive aspects of the premises which met residents' needs. Both of the community homes were homely and spacious. Residents had their own bedrooms which were personalised. One resident had their own key to their bedroom to ensure their own privacy and this was respected by staff who told the inspector this.

There was adequate communal space. One of the community homes was well maintained. However, as highlighted by the provider (and earlier in the report) one of the homes needed to be repainted and an outside building had not yet been converted into a sensory area for residents.

The inspector also found improvements were required in the maintenance of equipment records for the centre. For example; a sample of clinical and mobility equipment had tags attached stating that they had been serviced, however there was no comprehensive record to provide assurances that all equipment had been serviced appropriately.

In addition a washing machine which had been purchased in February 2019 in order to meet the needs of one resident had not been plumbed in at the time of the inspection despite the specific need for this facility having been identified. This did not show that the service was responding in a timely way to ensure issues which impacted on residents were addressed.

Residents were supported in their daily lives through a system of assessment and care planning. A sample of personal plans viewed found that residents had an up to date assessment of need completed. Support plans had also been developed to guide staff practice and these plans were reviewed by the staff.

Goals had been set for residents in line with their preferences and from a sample of records viewed, they had achieved their goals. For example; one resident went on holidays for two nights and attended a concert.

Activity schedules were developed for residents outlining what activities they had chosen. These schedules were developed into picture format in residents' bedrooms. Residents could avail of activities in the centre, some of which included mindfulness sessions and reflexology. While activities outside of the centre included shopping, walks, meals out and attending activity centres.

However, some compatibility issues which were impacting on residents' quality of life were identified. On review of two residents' plans it had been recommended by allied health professionals that in order to meet the residents' assessed needs, a more individualised model of care would be appropriate. These recommendations had been made in 2017 however, it was not demonstrated that the provider had put a plan in place to address this. It was also identified in records viewed and observed by the inspector that one resident's behaviours was impacting on another resident in the centre. For example; loud noises caused anxiety to another resident.

Residents were supported to have good health. They had timely access to allied health professionals in line with their assessed needs which included chiropody, general practitioner, psychology, clinic nurse specialist, psychiatry and occupational therapy. Some were being supported by staff and allied health professionals with their end of life care to enable them to remain in their own home.

There were fire safety arrangements in place in the centre which included the provision of fire doors, a means of escape, emergency lighting, a fire alarm and fire fighting equipment. All staff had completed training in fire safety. The records viewed in one community home demonstrated that all equipment had been serviced appropriately. A sample of documentation viewed also informed the inspector that staff undertook daily and weekly checks on all fire fighting equipment and where required, reported any issues or faults.

Personal emergency evacuation procedures (PEEP) had been developed for each resident. However, they had not been updated to reflect the actual support needs of the residents in the centre. Staff spoken to were also unclear about the information contained in these documents.

The most recent fire drill, conducted in May 2019 informed that all residents left the premises promptly when the alarm was sounded and no concerns were reported. However, some of these fire drills were simulated meaning that some residents did not participate – this was not clearly recorded in the records viewed. Some measures taken during this fire drill were also not included in the personal emergency evacuation procedures for one resident. The inspector was assured that the person in charge and the CNM1 took responsive action to address this on the day of the inspection until such time that this could be reviewed.

All staff had been provided with training to support residents to manage behaviours of concern and where required behaviour support plans had been developed to support residents. Allied health professionals were involved in the care and support of residents and had attended review meetings and reviewed documents relating to incidents in order to improve outcomes for residents. However, the behaviour support plans were not updated to reflect changes if any after these reviews were

conducted. The inspector found that this was not guiding staff practice given the amount of agency staff in the centre.

Some assurances were provided to the inspector through speaking to staff, that despite gaps in documentation, staff were implementing the agreed behavioural support changes from these reviews. They described how this had some positive outcomes for residents. For example, one resident was being supported to access the community through the use of some of the interventions in place.

Some restrictive procedures were in place in the centre. Residents or their representatives had consented to these interventions. From, a sample viewed they were recorded, reviewed and implemented as a last resort.

All staff had received appropriate training in relation to safeguarding residents and the prevention detection and response to any alleged abuse. There was a policy in place to guide practice in this area. Staff met, understood the different types of abuse and the procedures to follow in such an event.

Some safeguarding incidents had been notified to HIQA. All of these related to the impact of some residents' behaviours of concern on other residents in the centre. The inspector found that the person in charge had responded to these effectively and had put safeguarding measures in place to ensure that residents were being safeguarded. Staff were knowledgeable about these plans.

Residents had intimate care plans in place. They were detailed and outlined the specific wishes and preferences of the residents. This meant that resident's privacy and dignity was upheld during intimate care.

The risk management policy was not reviewed as part of this inspection. The inspector reviewed documents pertaining to the management of risks in the centre. Residents' risk assessments had not been updated since March 2017. The inspector found that this was not providing adequate oversight of risk management in the centre. For example; a significant number of incidents had been notified to HIQA in relation to incidents occurring in the centre. However, when the inspector reviewed a residents risk assessment it had not been reviewed since March 2017 despite being risk rated red. This did not provide assurance that there was adequate oversight of residents' individual risk assessments.

There were some effective practices in relation to risk. For example, there was a review system in place to identify trends and improve practices. Information from this review had been discussed at a staff meeting in the centre to ensure that staff were made aware of trends.

There were effective medication management practices in place in relation to the storage, administration, prescribing and disposal of medication in the centre. Medication was securely stored and a locked fridge was also in place to store medicines at the correct temperature.

The oversight and auditing systems in place ensured that medication management practices were safe in the centre. All medication delivered to the centre was checked

by staff. Weekly stock checks were also conducted to ensure that the medicines stored were correct.

An assessment had been undertaken for each resident to see if they wished to self-administer their own medication.

Regulation 17: Premises

Both of the community homes were homely and spacious. Residents had their own bedrooms which were personalised.

One of the community homes was well maintained. However, as identified by the provider, the other home needed to be repainted and an outside building had not been converted into a sensory area for residents.

There was no comprehensive record to provide assurances that all equipment had been serviced appropriately.

A washing machine which had been purchased in February 2019 in order to meet the needs of one resident had not been plumbed in at the time of the inspection.

Judgment: Not compliant

Regulation 26: Risk management procedures

While there were some effective risk management systems in place, there was not adequate oversight of some risks. For example, residents' risk assessments had not been updated since March 2017.

Judgment: Not compliant

Regulation 28: Fire precautions

Personal emergency evacuation procedures had not been updated to reflect the actual support needs of the residents in the centre. Staff spoken to were also unclear about the information contained in these documents.

The provider had not demonstrated that they could effectively evacuate the centre

at all times of the day and night.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were effective medication management practices in place in relation to the storage, administration, prescribing and disposal of medication in the centre. Medication was securely stored and a locked fridge was also in place to store medicines at the correct temperature.

The oversight and auditing systems in place ensured that medication management practices were safe in the centre. All medication delivered to the centre was checked by staff. Weekly stock checks were also conducted to ensure that the medicines stored were correct.

An assessment had been undertaken for each resident to see if they wished to self-administer their own medication.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The assessed needs of two residents in the centre were not being fully met at the time of the inspection. This had been identified by the provider, however, an effective plan to respond to it had not been put in place.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to have good health. They had timely access to allied health professionals in line with their assessed needs which included chiropody, general practitioner, psychology, clinic nurse specialist, psychiatry and occupational therapy. Some were being supported by staff and allied health professionals with their end of life care to enable them to remain in their own home.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans were not updated to reflect changes if any after reviews had been conducted by allied health professionals. The inspector found that this was not guiding staff practice given the amount of agency staff in the centre.

Judgment: Not compliant

Regulation 8: Protection

All staff had received appropriate training in relation to safeguarding residents and the prevention detection and response to abuse. There was a policy in place to guide practice in this area. Staff met, understood the different types of abuse and the procedures to follow in such an event.

Some incidents of alleged abuse had been notified to HIQA. All of these related to the impact of some residents' behaviours of concern on other residents in the centre. The inspector found that the person in charge had responded to these effectively and had put safeguarding measures in place to ensure that residents were safe. Staff were knowledgeable about these plans.

Residents had intimate care plans in place. They were detailed and outlined the specific wishes and preferences of the residents. This meant that resident's privacy and dignity was upheld during intimate care.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	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	Compliant

Compliance Plan for Teach Solas/Oaklands OSV-0003761

Inspection ID: MON-0023370

Date of inspection: 17/05/2019

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of staffing levels based on residents' assessed needs (to include social care needs) was carried out on the 01/07/19. Staff vacancies will be prioritized for recruitment and vacancies will be filled as per the derogation process in place. While awaiting recruitment of permanent staffing the service will continue to utilize agency staff who are familiar with residents. The person in charge will ensure all staff (including agency staff) have the appropriate knowledge, experience and skills to provide support for the residents. Relevant induction and training will be provided on an ongoing basis to ensure residents' assessed needs and preferences are met. Agency staff are booked directly by the centre manager to ensure consistency of regular staff. The staffing levels will be reviewed by the person in charge and Assistant Director of Nursing to address the findings of the initial review carried out on the 01/07/19 and to seek approval for further agency usage on the 23/07/19 where required.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A review of training requirements has been carried out by the person in charge of the centre. Dementia awareness training will have been completed for all staff by 31/07/19.	

Training for wheelchair clamping has been completed by those staff who were outstanding on the day of inspection.

Autism awareness training has been arranged for all staff in the centre and will be completed by 30/09/19.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Fortnightly meetings and weekly telecons attended by the Person In Charge and Assistant Director of Nursing to review governance and management in the centre commenced on 17/06/19. The meeting agenda includes quality and safety, risk management, staffing, behaviour support, residents' assessed needs, update on actions from audits, annual review and 6 monthly provider visits, maintenance and any other business deemed appropriate. Formal minutes are now maintained at this and all meetings. Decisions and actions from the meetings are identified and are reviewed at subsequent meetings. All actions which cannot be resolved by the person in charge are escalated to the Assistant Director Of Nursing and Regional Director Of Nursing for action. Where actions cannot be resolved by the Regional Director of Nursing these are escalated to the General Manager to ensure resolution.

The unannounced visit of the centre was carried out by a person appointed by the provider on the 03/04/2019. Regrettably on the date of inspection the report was not available in the centre. The report is now in the centre and all identified actions have been/are being addressed.

An action plan template has been developed to ensure that all actions required from audits, unannounced visits and annual reviews are addressed. The template includes the person responsible and the timeline for completion. There is a procedure in place to ensure all actions are addressed within the specified timeframe. The person in charge is responsible for ensuring actions are addressed and that actions which cannot be addressed locally are escalated. There is an escalation framework to ensure actions are escalated to the Senior Disability Services Management Team where they cannot be resolved by the Intellectual Disability Residential Management Team.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The person in charge has reviewed all complaints to ensure that the outcomes have been communicated to the complainant and that the level of satisfaction of the complainant is also documented. All complaints are reviewed monthly by the person in charge in conjunction with the Assistant Director of Nursing.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The washing machine which was not plumbed in on the day of the inspection has now been installed. An inventory of all equipment in the centre has been implemented by the person in charge in order to monitor the servicing and repair of equipment. This record will be maintained and reviewed monthly by the person in charge. A refurbishment plan including development of the therapeutic sensory area is being compiled and will be submitted to the provider representative by 31/08/19.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A review has been undertaken by the person in charge and all risk assessments (including residents' risk assessments) have been updated and will be reviewed monthly by the person in charge.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All personal emergency evacuation procedures (PEEPS) have been reviewed and updated	

to ensure that the actual support needs of each resident for fire evacuation has been documented and communicated.

A schedule has been implemented to record monthly, day and night time fire drills. A night time fire drill was carried out on 09/05/19 and residents were evacuated in 1 minute 56 seconds. A day time fire drill was carried out on 20/06/19 and all residents were evacuated in 1 minute 35 seconds.

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:
A review of the assessment of the needs of the two residents referenced has been carried out to include reviewing the current supports provided, compatibility and overview of their day to day life. These reports will be utilized to identify the supports required to ensure each individual is supported to spend time in a manner meaningful to each individual. The person in charge is currently formulating a plan to fully meet the needs of both individuals. The Assistant Director of Nursing and Regional Director of Nursing will ensure the plan is implemented in a timely manner.

In addition, the house will be reviewed with a view to ensuring that the resident who dislikes loud noises is supported to spend time in a quiet environment and not in the presence of those who make loud noises.

A M.D.T is scheduled for 30/07/19 for two residents that may require an individualised service. A business plan will be submitted after this date. This will be completed by 05/08/19.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All residents' behaviour support plans were reviewed and updated by the Behaviour Support Clinical Nurse Manager. All recommendations made by Allied Health Professionals have been included as part of the review. This was completed by 30/06/19.

A system to ensure all behaviour support plans are reviewed following recommendations

by Allied Health Professionals has been implemented and is overseen by the person in charge.

All behaviour support plans will be reviewed on a three monthly basis at a minimum and more frequently where required based on residents' assessed needs (or where a recommendation is made or review occurs by an Allied Health Professional).

All staff will receive support and guidance from the person in charge and the Behaviour Support Clinical Nurse Manager in regard to implementing residents' behaviour support plans to ensure residents are supported in line with their assessed needs.

Behaviour Support and restrictive practice is now a standard agenda item on monthly staff team meetings.

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	Orange	01/07/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	23/07/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Not Compliant	Orange	30/09/2019

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	22/05/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/12/2019
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as	Not Compliant	Orange	22/05/2019

	quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	22/05/2019
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	17/06/2019
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	Not Compliant	Orange	22/05/2019

	written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/07/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	22/05/2019
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily	Not Compliant	Orange	22/05/2019

	available as appropriate in the designated centre.			
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	22/05/2019
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	05/08/2019
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	30/08/2019