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:	Slieve Rua Residential & Respite Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	23 January 2023
Centre ID:	OSV-0003916
Fieldwork ID:	MON-0034604

About the designated centre

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

Slieve Rua provides a residential and respite service to 12 adults in three separate houses. This centre supports residents with low to high needs and can also facilitate residents with reduced mobility. One house is dedicated to respite and one resident uses this house for planned breaks. Two houses provide can residential care to up to five residents each. Each house in the centre is warm and comfortably furnished and residents' bedrooms are decorated with items of personal interest and photos of family and friends. The centre is located within walking distance of a small town in the West of Ireland. Some residents are offered an integrated service and some residents attend day services external to the centre. There is a staffing allocation to support residents during the day and there is a sleep in arrangement in place during night-time hours.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Monday 23 January 2023	10:45hrs to 18:15hrs	Angela McCormack	Lead
Monday 23 January 2023	10:45hrs to 18:15hrs	Eilish Browne	Support

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor compliance with the regulations. Inspectors found that in general residents enjoyed a good quality of life in this designated centre and that their rights and choices were promoted.

On arrival to the centre, inspectors were greeted by the person in charge who was based in one location in the designated centre. The designated centre comprised three houses, all located in close proximity to each other. One house accommodated five residents, one accommodated four residents (with one vacancy), and one house provided respite to one resident for nine nights per month and had the capacity to provide respite for two residents. Throughout the day inspectors met and spoke with the person in charge, members of staff and eight residents. One resident was at home with their family on the day, and one resident who received respite care in one location was not in the centre on the day of inspection.

Inspectors visited the three houses within this designated centre and got the opportunity to meet with eight residents and their support staff. On arrival to the first house, three residents were sitting at the kitchen table finishing off breakfast. One resident was attending an external day service and one resident was at home with their family. One resident spoken with told inspectors that they enjoyed living in the centre and that staff were very nice. One resident pointed out that they had got a new wheelchair recently and appeared happy about this. Residents appeared to be comfortable and happy in their surroundings. Staff were observed engaging with residents in a kind and caring manner and made sure that they made eye contact with residents in all interactions. It was clear from speaking with staff that they had a good knowledge of the care and support needs of all residents. One resident attended a day service and they met inspectors on their return. They had moved into the centre in October 2022 and appeared to be comfortable and happy in their new home. Inspectors were informed that some residents usually have reflexology on Monday mornings, however this was cancelled that day. Instead residents made a trip into the local town and on return they told inspectors that they enjoyed a hot chocolate while they were out.

There was a very friendly and warm atmosphere in this house. Each resident had their own bedroom, which was decorated in line with their preferences, with personal photographs and posters of their favourite musicians displayed in their rooms. Residents also had access to a spacious sitting room. The sitting room was recently furnished with a comfortable suite of furniture and appeared warm and homely and was decorated with ornaments and salt lamps. There was also a piece of artwork of a bird completed by one of the residents displayed in the sitting room. One of the residents in particular enjoyed spending time knitting in this room. The resident showed inspectors a colourful blanket that they had knitted with the support of staff members.

Throughout the inspection residents were observed to be comfortable and relaxed in

their surroundings. There was good comradery between residents. Three of the residents were observed enjoying their evening listening to their favourite musicians on technological devices, such as Daniel O'Donnell and Boyzone. Residents had access to technological devices, and one resident was observed enjoying playing interactive games on the device in the evening.

The garden area in this house was accessible and contained a variety of shrubs, plants and flower beds. The garden space also contained a water feature, solar lights and was decorated with ornaments and bird feeders. Some residents were involved in growing herbs and residents were reported to enjoy sitting out at the garden when the weather permitted. One resident was reported to like sitting inside the kitchen looking out at the birds in the garden. A comfortable chair had been set up beside a window to facilitate this, and was reported to be the resident's favourite spot to sit.

Through a review of documentation and observations it was found that residents were involved in the running of their home and they attended regular house meetings in which they discussed topics such as complaints, COVID 19, protection and feeling safe in their home. There were easy-to-read documents available to residents on topics such as food safety, protection, reporting abuse and how to cope with bereavement. Staff ensured that the rights of residents were protected and supported, and it was clear that this was promoted in this house. There was a visual rota on display in the communal area, which was located in an accessible area for wheelchair users. Residents were supported to access religious services on their personal devices and on the radio. It was reported that some residents were religious and that the local priest visited residents in one house once a month. The sacred heart picture was also displayed in the kitchen area of this house. The residents were also offered choices with regard to what they would like to eat throughout the day. Staff members told inspectors that residents enjoyed baking a soda bread and making soup once a week in this house. Staff spoken to on the day of inspection were found to have a good knowledge of the care and support needs of residents.

In another location of the centre, one inspector met with four residents. Residents greeted the inspector and communicated in their own way. Residents were observed to be relaxed and content in their home and with each other. There was a beautiful sensory room located in this house, and one resident was observed relaxing in a nest chair while listening to relaxing sounds in this room. Bedrooms were personalised and nicely decorated in line with residents' likes and interests. A visual communication system including objects of reference was observed in one resident's bedroom to aid them in communication. Two residents were observed coming and going for walks with staff during the inspection. One resident appeared relaxed sitting in the living room, where there was a television on in the background. Inspectors were informed that each resident in this house required one-to-one staff for outings. At the time of inspection, the position for a third staff during day time hours was vacant, and recruitment for this post was reported to be in progress. Staff spoken with appeared knowledgeable about residents' needs and were observed to be kind and caring in their interactions. One resident's healthcare needs had changed in recent months and staff spoke about this. However, care plans and

review of possible risks had not been comprehensively reviewed and updated.

One inspector visited the third house which provided respite care to one resident for a set number of nights each month. The resident was not receiving respite on the day, therefore the inspector did not meet them. This house required some internal maintenance work, some of which had been identified by the person in charge such as kitchen flooring replacement. It was observed that a blind in a resident's bedroom also required repair, and the room itself was bare and impersonalised. The premises also required improvements with regard to cleaning to ensure that it was hygienic at all times. One pillow required cleaning/replacement and the mop was sitting in the mop bucket in water outside the back door. In the sitting-room it was observed that the television was locked into a cupboard with clear Perspex screen, and some cupboards in this room were also locked. The person in charge was unsure why these were locked and undertook to follow up on this. In addition, there were fire safety risks in this house that had not been assessed, and this will be discussed further in the report.

Overall, residents were provided with good care and support; however improvements were required to ensure that the service was safe and to a high quality at all times. The next sections of the report outline the governance and management arrangements and outlines how this impacts on the quality and safety of care provided.

Capacity and capability

Overall, inspectors found improvements were required in the overall governance and management and oversight arrangements in the centre. Four regulations were found to be not compliant. These related to governance and management, staff training, risk management and fire safety. These will be discussed throughout the report.

The person in charge worked full-time and had responsibility for this centre only. They reported to a regional services manager, both of whom were involved in the management of the centre for a number of years, which helped to ensure good continuity of care.

The centre comprised three houses, one of which was a respite home. The skill-mix of staff were social care workers and social care assistants. Two staff were required to be in place at all times in two of the three houses and there were two staff providing sleepover cover each night in these two houses. The respite house was staffed by one staff day and night, with sleepover cover in place at night. From a review of the roster, this was evidenced to be in place. One house had a third staff for three hours each day to support residents to access preferred community activities. On the day of inspection, this position was vacant however, the provider

was in the process of recruiting for this position and relief staff were used to provide cover in the interim. The person in charge covered shifts at times also.

In general, it was found that residents were supported with familiar consistent staff who were knowledgeable about the needs of residents. There was a planned and actual roster in place, however this required improvements to ensure that it was accurate with regard to who was actually working in the centre at each day. A review of a sample of staff files also found that there were some gaps in the Schedule 2 documents, and this required improvements.

There were arrangements in place to ensure staff had access to training and refresher training; however there were significant gaps noted across the areas reviewed. On review of the staff training matrix a number of training gaps were identified in fire safety, medication administration, behaviour management, minimal handling and the national safeguarding vulnerable adults at risk of abuse training. The person in change had recently reviewed the training matrix and was aware of the gaps in training. This had been followed up with staff members and the training department, and some dates for future training courses had been received by the person in charge.

There were regular audits occurring in the centre by the local management team to monitor practices in the centre. This included audits in medication, finances, infection prevention and control and health and safety. In addition, the provider ensured that six monthly provider visits were completed, and that an annual review of the quality and safety of care had been completed. However, these audits required improvements as they failed to pick up on some issues identified on inspection such as fire safety arrangements in one location, and the identification and review of all restrictive practices in the centre. In addition, the time frames assigned to actions required review to ensure that they were realistic and achievable in the time frame assigned. Furthermore, the latest provider audit completed in November did not visit one location (respite house) and it was not clear on the previous two provider audits if they had visited this location also. There were fire safety issues found in this house that had not been identified through any audits. The monitoring and oversight of this location required improvements.

In addition, in another house where fire upgrade works had been identified since October 2019, this work had not yet been completed. While an action regarding assessment of these doors was highlighted on the last two provider audits, and noted that the action time frame was 'immediate', this had not been addressed and no time frame for completion identified. The person in charge spoke to the maintenance manager on the day, and verbal assurances were given to inspectors that the arrangements in this house were effective for fire containment, and it was explained that the works required were to upgrade aspects of the fire doors.

Overall, the arrangements for identifying risks, monitoring of each location and following up on actions that had been identified required improvements to ensure the ongoing safety of residents.

Regulation 15: Staffing

Staffing required some improvements, as follows;

- The recruitment of a vacant post in one house was in progress, and this required completion to ensure that residents were supported to access preferred community activities and were supported by a consistent staff team.
- There were gaps in Schedule 2 documents for some staff.
- The rota did not accurately reflect who was working in the centre

Judgment: Substantially compliant

Regulation 16: Training and staff development

On review of the staff training matrix a number of training gaps were identified. Three staff had never completed fire safety (practical) training while a further 13 staff members had not completed the fire safety (practical) refresher training. Training was also required for some other staff in Children first, behaviour management, minimal handling and the national safeguarding vulnerable adults at risk of abuse training.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clear governance and management structure in place with lines of accountability for members of the management team. Regular audits were completed by local managers and the provider. However, improvements were required in the ongoing monitoring and oversight of the centre including actions for improvement as follows:

- To ensure that local and provider audits effectively identified issues and actions to improve the safety for all. For example, some fire and premises issues had not been identified in one location.
- To ensure that actions identified in provider audits included a realistic and achievable time frame, and that these actions were kept under review to ensure that they are completed in a timely manner. For example, an action regarding assessment of fire doors was set at 'immediately' in the last two provider audits, and had not been completed.
- To ensure that all locations that formed the designated centre were visited as part of the provider's unannounced visits.

- To ensure that all restrictive practices were identified, assessed and kept under ongoing review.
- To ensure that staff training was kept under ongoing review to ensure that training needs were effectively identified and that a plan of action was developed to ensure timely response to training needs.
- To ensure that all risks in the centre that affected the safety and quality of care provided were identified and assessed as to what control measures were required to minimise the risk to residents.
- To ensure that residents' care plans were kept under review and updated when there was a change in need.

Judgment: Not compliant

Quality and safety

Inspectors found that residents were provided with person-centred care and that staff supporting them were knowledgeable about their individual needs and support requirements. However, improvements were required in the review of restrictive practices, in updating care plans to reflect changes in need, in ensuring the premises were clean and well maintained, in the assessment of risks and in fire safety arrangements.

A sample of residents' files reviewed found that residents' needs had been assessed with regard to health, personal and social care needs. Care plans had been developed where supports had been identified. Care plans consisted of a 'health action plan' and 'personal risk management plan'. However, it was found that one resident's change in need had not been reflected on their 'health action plan' or their 'personal risk management plan'. This created a risk that all staff would not be aware of the supports required. The resident's change in need involved the use of emergency medication in the event of seizure activity after a specific duration. However, on discussion with the person in charge and a staff member, the risks associated with the current staffing arrangements, such as sleepover staff in place, had not been fully assessed and documented. This required review and assessment to ensure that the resident was supported with all of their needs at all times.

A review of documentation and discussions with staff found that residents were supported to achieve good health, by being facilitated to attend allied healthcare appointments and to access national screening programmes and vaccinations as required. A number of residents required healthcare interventions and multidisciplinary input, and it was found that this was monitored and access facilitated as appropriate. Residents had end-of-life care plans developed.

There were no current safeguarding concerns in the centre, and residents were

reported to get on well with each other in general. This was observed on inspection also, where residents appeared comfortable in their environment and with each other. The training matrix reviewed by inspectors showed that a small number of staff had not completed training in Children First and in the online safeguarding awareness module, as required in the schedule. This is covered under regulation 16: Staff training and development. Residents had intimate and personal care plans in place which were found to be comprehensive and which guided staff to provide supports to residents in a safe and respectful manner.

Inspectors found that improvements were required in the identification and assessments of restrictive practices. In two locations, it was found that some cupboards were locked, and in one house the television was locked away behind a Perspex screen. The person in charge was not sure why this had been locked as they stated it was not a risk identified for the resident who availed of respite in this location. This required further review and assessment, and more effective monitoring of practices in this house.

In addition, in one location a sensor alarm was in place on one resident's bedroom door due to reported historic risks arising from behaviours of another resident. However, this had not been appropriately assessed as to what the specific risks were to warrant this, nor was the impact of this intervention on this resident appropriately assessed. While the resident's family representatives were aware of this measure, the risks were not clearly documented and it was not evident what alternatives had been reviewed to ensure that this was the least restrictive option. This restriction had been reviewed by the provider's rights review committee in 2016, with some recommendations made; however it was not clearly evident that these recommendations had been explored and it had not been reviewed by this committee since. This required review to ensure that it was the least restrictive option for the shortest duration.

The fire safety arrangements in the centre required review and follow up where actions to improve fire safety had been identified. As noted previously there was an action identified through a review in 2019, that some fire doors in one location required assessment. This was noted as an action in the last two provider audits, with the time frame set as 'immediate'; however this issue was still not addressed. In addition, in the respite location, it was found that the glass panels over the fire doors had been replaced with what appeared to be wood that was painted; however the person in charge was not aware if this measure was an effective fire containment arrangement or if it had been reviewed to determine this. In addition, this issue had not been previously identified through any management audits. Furthermore, a review of all fire doors were required as some intumescent strips had paint on them and there was slight wear and tear on one door. In addition, in one location a fire drill had not been completed to assess if evacuation could take place in a timely manner if evacuation had to occur through a back exit off the sensory room, and through a closed gate at the side of the house. The person in charge undertook to follow up on this.

Overall, it was found that the management and identification of risks required improvements. There was a risk management procedure in place and emergency

plans for adverse events. However, it was found that some risks had not been appropriately identified and assessed. For example; the fire risk assessments were not specific to each location and did not contain possible risks, such as firefighting equipment stored in closed containers and risks regarding fire containment. In addition, while the person in charge stated that healthcare needs of residents was the biggest risk in the centre, the risk of a resident requiring emergency medication due to seizure activity (which was a change in need since November 2022) at night time had not been clearly identified and assessed.

In summary, while care to residents was person-centred and residents were supported with their health, personal and social care needs, improvements were required to ensure that the service was safe and to a high quality at all times.

Regulation 17: Premises

Improvements were required in the maintenance and upkeep of one of the houses. The following areas required improvements;

- To ensure the repair/replacement of a blind in a respite bedroom
- To ensure hygiene practices were effective with regard to the storage of mops and mop buckets.
- To ensure the timely replacement of flooring in the kitchen area.
- To ensure that pillows used by respite residents were in a good state of repair and hygienic.
- To ensure that bedrooms used for residents were suitably decorated

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management required improvements to ensure that all risks were appropriately identified, assessed and kept under review, Improvements were also required to ensure that appropriate control measures were in place to minimise risks to residents. The following risks were required to be comprehensively assessed:

- Fire safety risks in one location were not effectively identified and assessed. The risk assessment did not include risks that were evident on the day of inspection such as; fire extinguishers being stored in closed containers in the hallway, and risks due to the replacement of glass sections over the fire doors in the bedrooms had not been identified and assessed as to whether they would be effective in containing fire.
- One resident's changing need meant that they may require emergency

medication after five minutes of having a seizure. However, the risks to the resident should they require this medication at night-time had not been assessed and this was required due to the sleepover staffing arrangements at night.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety arrangements required significant improvements as follows;

- To ensure that actions identified regarding the assessments of fire doors were completed in a timely manner. For example, an action identified in 2019 had not yet been completed, despite being assigned a time frame in the May 2022 and November 2022 provider audits as to be done 'immediately'.
- To ensure that checks on fire safety arrangements were effective in identifying issues with fire doors, fire containment arrangements and fire fighting equipment. For example; fire containment risks for the two bedrooms in the respite house had not been appropriately assessed or identified in any audits.
- To ensure that fire drills were carried out under different scenarios that may present, such as the possible need to evacuate from a back door and egress through closed gates.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Improvements were required to ensure that resident's care plans contained the most up-to-date information. For example, one resident's changing healthcare need and the supports required had not been included in the relevant care plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported with their healthcare needs and were facilitated to attend screening programmes, vaccination programmes and appointments with allied healthcare professionals as required. Residents had end-of-life care plans in place as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

Improvements were required in the assessments of some restrictive practices to ensure that they were proportionate to the identified risks, were used as a last resort and that the impact on the resident was assessed.

Improvements were also required in the identification, ongoing review and oversight of restrictive practices in place in the centre.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding of residents was promoted through staff training, reviews of incidents, discussion with residents about safety and in the development of comprehensive personal and intimate care plans.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were promoted in the centre. This was done through consultation at house meetings and the use of easy-to-read materials to support residents' understanding of topics. Through a review of documentation, discussions with staff and observations, residents were found to be supported to make choices regarding meals, activities and in practicing their faith. There was evidence that one resident had been supported to access and avail of independent advocacy services in the past.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Slieve Rua Residential & Respite Services OSV-0003916

Inspection ID: MON-0034604

Date of inspection: 23/01/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Person in Charge will progress the recruitment of a vacant post to ensure that residents are supported to access community activities - 30.04.2023 • The Person in Charge has ensured that the Schedule 2 documents for some staff has been updated and correct - 28.02.2023 • The Person in Charge has reviewed and updated the rota to ensure it accurately reflects who is working in the center - 10.02.2023	
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 Person in Charge has reviewed all staff training and nominated staff for all outstanding training for example behaviour management, minimal handling. 30/04/2023 • The Person in Charge scheduled a bespoke fire training course on Wednesday 08.02.2023 for staff requiring this training, one staff will attend event on 14/03/2023. • The Person in Charge has ensured that staff who required training in Children First and safeguarding adults at risk of abuse will be completed by. 10/03/2023	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The provider will conduct an additional internal unannounced visit/ audit in the designated centre ensuring all locations are visited. 31/03/2023

• The provider will liaise with relevant departments to ensure that timelines on actions are realistic and achievable. 31/03/2023

• The Provider will ensure that all locations within the designated centre are visited as part of the internal unannounced visit 31/03/2023

• Restrictive practices will be reviewer by the PIC on a quarterly basis, this will be discussed with the PPIM in monthly Support and Supervision meetings commencing. 28/02/2023

• The Person in Charge will review the training need within the designated centre on monthly basis, this will be represented to the Training Dept via organizational nomination system on a Quarterly basis. This will be reviewed with the PPIM at monthly Support and Supervision meetings. 28/02/2023

• A review of the Centre risk register will be completed by the PIC, all risk that affect the safety and quality of care provided are identified and assessed. 02/03/2023

• All Care plans will be Audited/reviewed by the Person in Charge and Named Staff on a Quarterly basis to ensure that they are up to date and capture any changing needs. These reviews will take place in Support and Supervision and Staff meetings.
• 15/04/2023

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Person in Charge will ensure that the blind in the respite room will be replaced - 30.03.2023
• The Person in Charge will review and monitor the hygiene practices within the respite service and ensure that this is shared with all staff. 10/03/2023
• The Person in Charge has ensured that the floor covering was replaced in the kitchen area - 10.02.2023
• The Person in Charge has replaced the pillows used by the respite residents
• The Person in Charge will work with the resident to ensure their bedroom is suitably decorated and personalized. 10/03/2023

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge will review and update the center's risk register to include assessment of risk posed by; fire extinguishers stored in closed container, risk posed by replacement of glass panels over bedrooms in one location and risk to resident due to changing needs and night time support. 02/03/2023
• The Person in Charge will follow up with Fire equipment services to secure extinguisher that are easily accessible. 09/03/2023
• An assessment has been completed on the fire containment risks in one location. Fire resistant slabs are now in place to address any fire risk. - 17.02.2023
• A risk assessment has been completed on one resident's night time support requirement. An Epilepsy monitor was identified as a control to support this resident. The monitor is now ordered and will be in place by. 31/03/2023 In the interim a sensor monitor is in place.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Maintenance Manager will work with the Person in Charge to ensure that all fire doors are assessed and identified repairs are carried out.
23.04.2023
• An assessment has been completed on the fire containment risks in one location. Fire resistant slabs are now in place to address any fire risk. - 17.02.2023
• The Person in Charge will ensure that weekly fire checks are completed within the respite service . Health & Safety Audits will be carried out on a monthly basis by the Person in Charge. 03/03/2023
• The Person in Charge will ensure that fire drills are carried out under different scenarios using different exits - 30.03.2023

Regulation 5: Individual assessment	Substantially Compliant

and personal plan	
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • The Person in Charge will ensure that the resident's care plan is reviewed and updated and will contain the most up to date information taking into consideration the residents changing needs and supports required - 27.02.2023	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • The Person in charge has complete an assessment on restrictive practices within the designated center. A number of locked cupboards (in bathrooms) have remained in place, and have been recorded in the restrictive practice logs, this is also reported in Quarterly returns to HIQA on 31.01.2023. • Following the assessment, a number of locked cupboards in the respite house are now unlocked.17/02/2023 • The Person in Charge will update the restrictive practice logs to include all changes identify in regards to any restriction. 28/02/2023 • The Person in Charge will reassess restrictions that impact individual residents and forward to the Rights Review Committee for review, support and guidance. 31.03.2023	

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(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.	Substantially Compliant	Yellow	30/04/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	10/02/2023
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	28/02/2023

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	13/04/2023
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.	Substantially Compliant	Yellow	30/03/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	10/03/2023
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	15/04/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Not Compliant	Orange	31/03/2023

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	23/04/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	17/02/2023
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.	Substantially Compliant	Yellow	30/03/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances,	Substantially Compliant	Yellow	27/02/2023

	which review shall take into account changes in circumstances and new developments.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/01/2023
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/03/2023