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:	The Ash
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	07 March 2023
Centre ID:	OSV-0004759
Fieldwork ID:	MON-0037464

About the designated centre

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

This centre is located in a residential area on the outskirts of the busy town; the location facilitates access to a range of services, shops and recreational opportunities. The premises is a bungalow type residence consisting of 2 distinct units respectively known as 'The Front House' and 'The Apartment'. The front house provides accommodation for two residents and the apartment provides self-contained accommodation for one resident. The apartment is currently unoccupied. The centre operates fifty-two weeks of the year providing wraparound residential and day supports for residents with low to high support needs in the context of their disability and other needs such as physical and health needs. Residents are supported by a staff team comprised of social care workers and support workers. Management, oversight and the general operation of the centre is currently delegated to a co-ordinator supported by a social care worker under the direction of the person in charge who has overall responsibility for the day to day management of the service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 7 March 2023	10:00hrs to 17:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to monitor the provider's compliance with the requirements of the regulations and standards. Improvement was noted, the provider was progressing its own quality improvement plan for the service and, an improved level of compliance with the regulations was found. The inspector found an improved system of governance that was focused on providing each resident with a safe, quality service and, a good quality of life. This commitment was reflected in inspection findings such as the improvements made in promoting residents' healthcare needs and the increased awareness of restrictive practices.

However, further improvement was still needed. For example, in areas such as risk identification and management and, much work was needed to improve and enhance the suitability and maintenance of the physical environment. The provider was aware that it was on a pathway of improvement and had plans in progress. Notwithstanding the works planned, one area of the house required a deep clean.

On arrival at the centre the inspector saw that all staff on duty were wearing a surgical face mask as required by the providers current infection prevention and control guidance. Staff were diligent in establishing that the inspector was well and free of symptoms that may have been indicative of illness that could have been transmitted to the residents and staff.

The inspector noted the relaxed and happy atmosphere in the house and this was evident throughout the day when staff members and residents were present. The inspector's observations of staff and resident interactions were positive. The residents presented as at ease in their home and with the staff members on duty. Two residents were at home as the provider had since the last HIQA inspection reduced the occupancy of the house from three to two residents. The provider had applied to HIQA to have this reduced capacity formally reflected in the centre's registration conditions.

One resident was up and about and busy getting ready for a clinical appointment. Much progress had been achieved with and for this resident in developing the resident's ability to cope with medical reviews and interventions. The resident uses manual signing and gestures to communicate. The resident who has previously met with the inspector used these communication methods to communicate to the inspector how for example they had had extensive dental work completed. When the resident returned from the clinical appointment they had on the day of inspection the inspector saw that the resident had control of their own appointment record and again using gestures the resident provided feedback of what had happened during the appointment. The resident had receipts for monies they had spent and gave these to staff on duty. Some staff members were noted to be competent in using manual signing to communicate with the resident.

The staff members on duty were clear on the plans for the day and their assigned responsibilities. For example, a staff member who had a good and established relationship with this resident was to provide the support needed for the clinical appointment so as ensure the success of the appointment. This staff member told the inspector that the resident was, following the appointment free to choose how they spent the rest of their day.

The second resident was recovering from an injury and is currently dependent on a wheelchair to get around the house and to access the community. The resident looked well and did not present as challenged by their current immobility. The resident greeted the inspector by gesture and directed the inspector's attention to their injury. The resident said that it was sore but the inspector saw from records reviewed that the staff team monitored the resident's wellbeing including any pain and discomfort that they might have and, administered prescribed pain relief as needed.

Both residents spent much of the day coming and going with staff members and when they returned in the evening they both eagerly shared with the inspector items they had purchased such as a pair of sunglasses and some new items of clothing. The resident used gestures to describe how they had purchased the sunglasses in response to the unexpected sunshine on the day.

Staff members spoken with were satisfied that the staffing levels were sufficient to meet the individualised needs of the residents including these increased needs. The inspector saw that the staffing levels supported individualised routines. However, the provider had an active business case submitted to its funding body for enhanced staffing. This will be discussed further in the next section of this report.

The day-to-day management of the service was delegated to a co-ordinator and a recently appointed social care worker. They were both clear on the status of the service specific quality improvement plan and described the arrangements in place for supporting and guiding the staff team. Staff on duty were confident in their practice. However, there was some outstanding staff training.

Feedback had been sought from and had been provided by resident's families so as to inform the 2022 annual review of the service which was in progress. Residents had ongoing access to family either in person or by using media. One resident showed the inspector a photo of family members and used manual signing to indicate how they hoped to save some money so as to go and visit.

In summary, the inspector was assured based on these inspection findings that while improvement was still needed, improvements had been made and residents had benefited from these improvements. The provider was progressing its own quality improvement plan.

The next two sections of this report will discuss the findings of this inspection in greater detail and describe the governance and management arrangements in place and, how these impacted on the quality and safety of the service provided to residents.

Capacity and capability

There were management systems in place that were focused on ensuring that the service provided was safe, consistent and appropriate to residents' needs. However, while improvement was found, further improvement was still needed for example in the areas of risk identification and management, in personal planning and, ongoing oversight of restrictive practices.

The person in charge was supported in the day-to-day management and oversight of the service by a co-ordinator and a social care worker both of whom worked full-time. There was clarity on individual roles and responsibilities and reporting relationships.

The co-ordinator and the social care worker maintained an active presence in the service and were progressing the service specific quality improvement plan as it related to their scope of responsibilities. For example, a schedule for formal staff supervisions and staff meetings was in place. The co-ordinator described how to ensure these processes were effective, they were tailored to the specific needs arising in this service and areas identified for improvement by internal and external reviews.

This relevance was also reflected in the staff training programme. For example, the face to face training provided recently to staff on physical interventions in response to behaviours that challenged including unplanned interventions. However, there were staff members that had yet to attend such site-specific training and there were some gaps in staff attendance at refresher training.

The staff rota was well maintained and a review of the rota indicated that the agreed staffing levels and arrangements were maintained. Nursing advice and care was accessed as needed from within the provider's own resources and community based services. The staffing levels observed on the day of inspection presented as sufficient to meet the needs and choices of each resident. However, one resident required one-to-one staff support at all times by day and there was only one staff member on duty each day from 16:30hrs to support both residents.

On balance, the provider was effectively collecting and using data to both monitor and improve the appropriateness, safety and quality of the service. For example, the six-monthly internal reviews required by the regulations were completed on schedule. The reviews were comprehensive. The most recent review captured the progress that had been made but also the improvement that was outstanding.

Registration Regulation 8 (1)

The provider submitted a complete and valid application seeking a variation to the registration conditions of this designated centre.

Judgment: Compliant

Regulation 15: Staffing

There was only one staff member on duty each day from 16:30hrs and one resident required one-to-one staff support at all times. While there was no evidence of direct impact, there was some risk that these staffing levels limited evening choices and routines for residents. A further concern was the need for additional staff resources once the provider reconfigured each resident's living arrangements. It was planned that each resident would have their own largely self-contained area of the house and this would require additional staffing resources. The provider had an active business case in this regard seeking the resources needed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Site specific training had been provided so that staff members had the knowledge and skills to respond to the needs of the residents. For example, external facilitators had been engaged to provide training in areas such as in personal and intimate care and falls prevention. However, all staff had not yet completed this resident needs specific training and, based on the inspectors review of the staff training matrix there were also gaps in staff attendance at refresher training such as manual handling, fire safety and the management of seizure activity. Further in-house training was planned.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was evidence of improved management and more consistent oversight of the appropriateness, quality and safety of the service. The impact of this was evident. However, while good progress had been achieved there was an active internal quality improvement plan. These HIQA inspection findings also indicated that further

action was still needed. For example, in relation to personal planning and risk management. Changes were planned to the governance structure and assurance was required that that governance structure would have the capacity to provide the ongoing oversight required in this service, to sustain the improvements made and, to progress the quality improvement plan.

Judgment: Substantially compliant

Quality and safety

Improvements were still needed but much improved systems were in place for reviewing and overseeing the appropriateness and the evidence base of the support and care provided to each resident. The positive impact and the benefit to residents of this improved oversight and guidance was evident.

For example, as discussed in the opening section of this report one resident was now attending clinical appointments and reviews that they had previously found challenging such as vaccination. The resident was clearly delighted with their achievements. There were plans in place in response to healthcare needs and, daily monitoring records completed by staff were in line with the instructions of the plans. The annual review of the overall personal plan particularly in relation to residents' personal goals and objectives was however overdue.

Both residents had a positive behaviour support plan and one of these had been recently reviewed with the staff team in conjunction with the behaviour support team. On-site training had also been provided to some of the staff team on the use of planned and unplanned physical interventions. Overall, the inspector found increased awareness of what constituted a restrictive practice and some reduction in the interventions in use. There was still some inconsistency however in the area of positive behaviour support and restrictive practice.

The reduction in occupancy from three to two residents had reduced the level of risk that presented in this service. The register of risks was up-to-date and did reflect some but not all risks arising in the centre and how they were controlled. In general, risk identification and management needed to be more specific to the needs and circumstances arising in the service and changes in those needs.

The provider was progressing plans for the reconfiguration and refurbishment of the premises. However, these plans needed to be prioritised given the changing and increasing needs of the resident. The presentation of some areas of the premises as evidenced on this inspection was not good.

There was better oversight of fire safety arrangements such as the scheduling of simulated evacuation drills. Three meaningful and successful evacuation drills in which both residents and staff members had participated were completed since the last HIQA inspection. However, again it was an area that needed more

comprehensive oversight. For example, there was a tumble dryer and a freezer in use in the external timber storage shed but no evident fire or smoke detection device.

Regulation 10: Communication

Both residents had communication differences. The inspector saw that residents were spoken with and staff members on duty were competent in their use of manual signing. The inspector observed no communication difficulties or challenges. The visual schedule was in use in the format recommended following clinical review. The co-ordinator had followed-up on and was progressing recommendations made to develop resident communication skills and abilities.

Judgment: Compliant

Regulation 11: Visits

Other than the infection prevention and control measures in place there were no restrictions on visits. Family were welcome to visit the centre and residents were supported to have ongoing contact with their family members using the appropriate media.

Judgment: Compliant

Regulation 17: Premises

The provider had plans to reconfigure the design and layout of the house to improve its suitability to the different needs and abilities of the residents. However, while the provider was progressing these plans residents needs were changing and increasing. For example, while recovery was likely, one resident was wheelchair dependent in the house and in the community. Doorways, circulation areas and some room spaces are narrow and compact. While ramped, there was a steep incline to the front of the house. There was an ongoing need for some restrictive practices because residents had different needs and risks but shared the same facilities such as the kitchen. The vacated apartment was in the process of being cleared but it was in a very poor, unpleasant and unhygienic condition. The external storage shed was untidy and poorly maintained and posed a risk for cross-contamination because it was used for services and facilities associated with the designated centre. For example, unsealed stocks of personal protective equipment was stored in the shed. There was a freezer with food in it also in the shed. However, there was evidence of

bird activity in the shed and items such as unused furniture and gardening equipment were also stored in the shed.

Judgment: Not compliant

Regulation 26: Risk management procedures

The identification and management of risk needed to be more specific to the needs and circumstances arising in the service including any changes in resident needs and, any incidents and accidents that occurred. For example, one resident was currently wheelchair dependent but there was no risk assessment or plan for resident transfers and increased manual handling needs. There was no risk assessment for the safe use of the manual wheelchair in the house and in the community. For example, the steep incline noted at the front entrance. Better detail was needed in the falls prevention and management risk assessment and plan given that the residents needs were now different and the risk for falls was different. For example, the risk of getting up unaided and then falling. A better link was needed between the use and reduction in the use of any restrictive practices and risk management.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The fire safety procedure and the overall emergency evacuation plan required updating as they still referenced the accommodation of three residents. There was no fire or smoke detection device in the external timber shed that contained a freezer and a tumble dryer and so posed a fire risk to the designated centre. A wedge was used to hold open the door of the staff office. The scheduling of future drills needed to consider and prioritise the participation of four staff listed on the staff rota.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents were out and about each day with staff. The co-ordinator had sourced transport that was more suitable to the changing and increased needs of one resident. The MDT was inputting into the assessment of residents' needs and the plans of support and care. The support provided was monitored to ensure it was in

line with any recommendations made. However, while there were current individual plans of support in place the annual review of the plan particularly in relation to identifying, agreeing and progressing each resident's personal goals and objectives was overdue.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had health care needs and these needs were increasing. The inspector saw that there were plans in place to guide staff on the care that was to be provided and staff members completed daily records and monitoring tools that were in line with the care plans. These daily records demonstrated that staff were attentive to residents' needs and wellbeing and sought advice and care for residents when they had any concerns. As discussed throughout this report good progress had been made in facilitating healthcare for one resident where previously they had not consented to such care. Residents were supported to have access to the clinicians and services that they needed such as their general practitioner (GP), speech and language therapy, occupational therapy, physiotherapy and community based services such as the local community intervention team. Clinical recommendations were seen to be followed up on, for example, a request for blood profiling. There was scope for improvement such as in relation to manual handling and falls prevention; this was addressed above in the context of risk management.

Judgment: Compliant

Regulation 7: Positive behavioural support

The reduced occupancy of the centre had reduced the number and intensity of behaviour related incidents. There was an increased awareness and some reduction in the restrictive practices in use. For example, there was no evidence of unplanned physical interventions and the door to the secure garden area was unlocked. However, one positive behaviour support plan was awaiting review and following this review there was scope to further develop and consolidate staff knowledge and staff responses including the use of any physical interventions. This was needed to ensure that staff responses were always objective, consistent and used only as a last resort. On-site training had been provided to some but not all staff members. Some restrictive practice protocols (required by the providers own policy) were outstanding including one for the use of the wheelchair lap-belt.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The practice observed was respectful and individualised to the needs of each resident. As appropriate to the level of ability residents were supported to have access to and enjoy their personal monies and residents had adequate space for their personal possessions. A staff member spoken with confirmed how a resident would choose and decide their own daily routine and the resident was supported according to these choices. The co-ordinator described how the phased reduction in the use of restrictive practices was supported by developing staff awareness of residents' rights such as their right to access all areas of their home provided it was safe for them to do so. Senior management was currently discussing the roll-out of human rights training to all staff.

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	
Registration Regulation 8 (1)	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Ash OSV-0004759

Inspection ID: MON-0037464

Date of inspection: 07/03/2023

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: Rosters will be reconfigured to ensure the adequacy of staffing levels, based on the person supported choice of schedule and suited to the service needs. (To be completed by 31st April 2023) The Senior Management team along with the service leader will continue to progress business case to the HSE for additional funding to ensue persons supported receive continuity of care and a consistent quality service, suited to their identified needs. To be raised at quarterly meeting with HSE in May 2023. (Completion 31/07/2023) Vacancy Review Forms to be completed by PIC/Co-Ordinator and progressed in order to ensure there is adequate staffing resources available as per service needs. (Completed) (Overall completion by 31/7/2023)	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In order to ensure compliance with Regulation 16 (1) (a) the training needs of all staff has been reviewed and a risk assessment has been completed in relation to training requirements identified and will continue to be reviewed. (Completed) Training Matrix to be reviewed by PIC/SCW on a monthly basis to ensure all training	

needs and refreshers are completed in a timely manner (To be reviewed monthly)

The PIC will work with the Training Department to identify a number of additional training for staff to include Human Rights Training to support staff in identifying and promoting the rights of those supported on a daily basis. (To be completed by 31st June 2023)

All staff booked to attend training in Personal Outcome Measures in order to ensure the residents goals are identified and they are supported to progress these. (To be completed by 31st April 2023)

The training needs for all staff will be reviewed in order to ensure that training delivered supports understanding and skill development for all, in ensuring person centeredness and respect at all times towards the person supported. These will include Positive Behaviour Support, Risk Management, Human Rights, POMS, Safety Intervention and Report Writing (To be completed by 15th May 2023)

(Overall completion 31/6/2023 and monthly thereafter.)

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PICs caseload has been reviewed by senior management and has been reduced so the PIC can dedicate sufficient time to the governance and management as well as the quality improvement of the overall service. (Completed 01/04/2023)

Rosters will be reconfigured to ensure oversight by PIC/SCW of the day to day running of the DC. (31st April 2023)
To ensure a consistent and timely oversight of the service the PIC will base herself in the DC throughout the week to ensure appropriate governance and oversight of the service. In additional to this the SCW will also be on duty throughout the week. Further to this senior management will visit the service sporadically for additional oversight and governance. (Completed)

Staff Support and Supervision and Performance Enhancement scheduled with team members. Schedule of Support and Supervision identified for every five to six weeks on a continuous cycle. (Completed)

In order to ensure that management systems are in place in the designated centre to ensure safe service provision, appropriate to residents' needs the PIC will ensure that

actions identified in annual reviews, internal audits and HIQA inspections are completed in line with timelines agreed. (To be completed by 30th June 2023)

The PIC and Community Manager will review and update current risk assessments in the centre to ensure all control measures have been outlined in each respective risk assessment and they are proportional to the risks identified. (To be completed by 30th April 2023).

Quality Improvement plan will be reviewed on a monthly basis by PIC/SCW and Community Manager to identify progress and barriers encountered. (To be completed monthly)

Overall completion by 30/6/2023.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Consideration will be required as to the placement of the residents while upgrade works are being carried out – the service will strive to minimize the impact of the disruption on residents at all times with suitable accommodation will be identified while works are carried out. HIQA will also be notified of this move and the arrangements in place (To be completed by 1st May 2023)

The PIC, supported by the community manager, regional manager and facilities manager has identified the areas of the premises that require additional works and upgrade to the DC in order to ensure the immediate and changing needs of those supported are been adequately met. A scope of works has been completed with the involvement and oversight of a competent architect and this is currently being prepared for tender. (To be completed by 19th May 2023).

The PIC, supported by Senior Management and Facilities will ensure that the procurement process is completed for all required works and that a contractor is appointed to carry out works. (To be completed by 30th May 2023)

The PIC will ensure that consideration is given to the layout of the newly renovated DC to ensure residents are not subject to restrictive environments and their human rights are considered and promoted. (To be completed by 31st September 2023)

External storage facilities attached to the DC will be reviewed and the PIC/SCW will ensure that they are maintained in an appropriate and safe manner in order to comply with Regulation 17 (1)(a) and Regulation 17 (1)(c). (To be completed by 30th May 2023)

(Overall completion proposed by 31/8/2023.)

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC and Community Manager will review and update current risk assessments in the centre to ensure all control measures have been outlined in each respective risk assessment and they are proportional to the risks identified. (To be completed by 30th April 2023).

The PIC will complete an overall review of all risks in the designated centre, and where appropriate identify where risks currently managed within the centre have not been included in the current risk register; and will ensure all monitoring of risk is evident in the assessments. (To be completed by 30th April 2023)

The PIC, Community Manager and SCW along with the staff team will review any restrictive practices in the designated centre and will update risk assessments in the centre to ensure all control measures have been outlined in each respective risk assessment and they are proportional to the risks identified. (Completed).

(Overall completion by 30/4/2023)

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC will update the Fire Safety Procedure to reflect the emergency evacuation plan and occupancy levels at the DC. (Completed)

External storage facilities attached to the DC will be reviewed and the PIC/SCW will ensure that they are maintained in an appropriate and safe manner in order to comply with Regulation 28 on Fire Precautions. (To be completed by 30th April 2023)

Staff training will be reviewed and site specific fire training will be provided. (To be completed by 6th April 2023)

All remaining staff on the team will have completed a simulated drill by 1/08/2023 and records of such will be available in the Fire Folder. Fire Drills will (To be completed by 1st August 2023)

PIC will ensure that door closure mechanism on the staff office door is replaced and in working order in case of fire. (To be completed by 18th April 2023)

(Overall completion by 1/8/2023.)

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All staff will attend training on Personal Outcome Measures (POMS). This will inform staff on the process to support residents with goal setting and achieving the identified goals. The POMS once completed will be reviewed and updated to reflect the individuals wishes. (To be completed by 30th April 2023)

Oversight of the POMS will be provided by the PIC and SCW whom will monitor the daily activities to ensure consistency between the individuals POMS plan and daily activities. Support and guidance will be given to all staff in this regard and failure to implement actions and support individuals achieve their identified goals will be addressed through the organisations performance enhancement process. (To be completed by 30th October 2023)

PIC and SCW will ensure support note templates are devised to capture the identified and changing needs of the person supported. (Completed)

The PIC and Community Manager will review rosters to ensure the adequacy of staffing levels, based on the person supported choice of schedule and suited to the service needs. This will focus on extended evening support to ensure persons supported can access activities later in the evening. (31st April 2023)

Overall completion by 30/10/2023.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Positive Behaviour Support Plans will be reviewed with team and PBSS. (To be

completed 28/03/2023 and 18th April 2023)

The PIC, Community Manager and SCW along with the staff team will review any restrictive practices in the designated centre and will update risk assessments in the centre to ensure all control measures have been outlined in each respective risk assessment and they are proportional to the risks identified. (Completed)

The training needs for all staff will be reviewed in order to ensure that training delivered supports understanding and skill development for all, in ensuring person centeredness and respect at all times towards the person supported. These will include Positive Behaviour Support, Risk Management, Human Rights, POMS, Safety Intervention and Report Writing (To be completed by 15th May 2023)

The PIC will review AIRS reports with the team at team meetings and a minimum of quarterly analysis of AIRS will be carried out with the PIC and reviewed by the Community manager to ensure comprehensive review of all incident and potential tends. (Complete and ongoing)

SLT to be identified for person supported in order to support him to develop his communication skills and to guide staff in a consistent approach with the resident (To be completed by 30th May 2023)

The PIC will ensure that all restrictive practices in the centre are reported to HIQA as per the required criteria (Quarterly as required).

The PICs caseload has been reviewed by senior management and has been reduced so the PIC can dedicate sufficient time to the governance and management as well as the quality improvement of the overall service. (Completed 01/04/2023)

The PIC and SCW will continue to support staff with understanding and working within the guidelines of the Positive Behaviour Support Plan, by ensuring enhanced oversight in the DC on a daily basis. (Complete and ongoing)

Overall completion by 30/5/2023.

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(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.	Substantially Compliant	Yellow	30/07/2023
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.	Substantially Compliant	Yellow	30/06/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/08/2023

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/08/2023
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.	Substantially Compliant	Yellow	30/06/2023
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.	Substantially Compliant	Yellow	30/04/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	01/08/2023

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	01/08/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/10/2023
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	30/10/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Substantially Compliant	Yellow	30/05/2023

	to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/10/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/05/2023