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 Elms
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	10 May 2023
Centre ID:	OSV-0004877
Fieldwork ID:	MON-0035782

About the designated centre

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

In this centre, a residential service is provided for a maximum of seven residents over the age of 18 years. The service provided responds to individual requirements with some residents availing of a less than full-time service. The centre is comprised of three separate premises, two of which are located in the suburbs of the main town and one in a village approximately 15 kilometres from the main town. Currently two residents live in each of these houses. One house has an additional apartment attached where one resident resides. Each premises provides residents with access to their own bedroom, some en-suite facilities, shared bathrooms, sitting rooms, kitchen, dining areas, front and rear gardens. The model of care is social and staff are on duty both day and night to support the residents who live in this service. Management and oversight of the day to day operation of the service is undertaken by the person in charge supported by a coordinator and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Wednesday 10 May 2023	10:00hrs to 18:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to follow up on the findings of the inspection completed in April 2022. The provider had submitted to HIQA an application seeking changes to the conditions of registration attached to this centre. This included a requested extension to the time-frame by which certain non-compliance's were to be addressed by the provider.

Currently the centre is comprised of three separate houses across which accommodation is provided for seven residents. Six residents currently live in the centre some on a fulltime basis and others on a less than fulltime basis where they reside at home with family two to three nights each week. The inspector recently visited one of these houses and met with the two residents living there. For this inspection the inspector was based in another house and met with a further two residents. Residents in the third house had a planned social activity on the evening of this inspection and were not met with. However, the inspector reviewed records and discussed their care and support with the management team.

There was evidence of actions taken by the provider that had reduced the level of risk in the centre and improved the quality of life for residents. There was evidence of an ongoing commitment to make further changes so that each resident enjoyed the best possible safe, quality service. However, there were unresolved matters. For example, the provider itself knew that matters such as providing the required staffing levels and a more appropriate living environment were not satisfactorily addressed. There was evidence of an absence of compatibility between the residents living in both of these houses. The inspector was not assured the appropriate arrangements were in place that ensured each resident received the support they needed to understand and manage behaviours that challenged others.

On arrival at the house the inspector noted the external and internal improvements made by the provider to the house. These included extending and enhancing the security of the external space available to a resident and extending the available internal space. This meant that the resident who had an apartment to the rear of the house now also had a room to the front of the house. The inspector saw that the resident sat contentedly at the window watching the general activity of the house and the estate. Staff reported that the resident was well known to their neighbours who acknowledged and waved to the resident as they passed. This resident in the context of their assessed needs was not able to tell the inspector what their daily life was like. The resident was noted to be relaxed and content on the day of inspection. There was an easy rapport between the resident and the staff member supporting them. The resident successfully spent some part of their day out of the house attending a therapeutic programme and other activities in the community with the support of two staff members.

The second resident had a very busy day with planned activities such as hiking and swimming. This resident engaged easily with the inspector. The resident

remembered having met with the inspector previously and also enquired as to the wellbeing of another inspector. There was discussion of activities that the resident clearly enjoyed such as their hiking trips. There was discussion of home and family, events they had enjoyed and events that they hoped to attend with support from staff such as concerts. However, what was also evident from this discussion was the absence of compatibility between these two residents. This was clearly referred to by the resident when speaking with the inspector. The resident also spoke of the security provided by the locked doors between their segregated areas of the house. Ultimately however, their current living arrangements were not the most conducive to either resident's needs.

The inspector did not meet with any resident representative but saw feedback provided by two families. This feedback was requested by the provider as part of their annual review of the service. The feedback was positive. One family had rated the service as excellent, the other as good but no specific concerns or areas that could be improved were identified on the questionnaire. Residents had regular access to home and regular visits to the centre were facilitated.

There was a relaxed atmosphere in the house and the inspector noted an easy familiarity between the staff members on duty and both residents. For example, as the inspector was leaving the house one resident and a recently recruited staff member were observed walking and chatting amicably as they made their way back to the house. However, while some improvement had been made the provider did not have the staffing levels and arrangements in place to meet the assessed needs and risk of one of these residents. The inspector was advised that the provider had submitted a business case to its funding body but the provider had not received the required resources despite having made reasonable efforts to do so. This ongoing staffing deficit limited the quality and safety of the resident's service.

In summary, the efforts made by the provider to improve the quality and safety of the service were evident and improvement was noted. However, there were obstacles and challenges such as these staffing deficits that continued to limit and did not assure the provision of the best possible safe, quality service to all residents. There was evidence of good day-to day management but there were some gaps in oversight. Improvement was needed in the wider governance of the service to ensure that actions needed for improvement were progressed so that the best possible service and outcomes for each resident were achieved. For example, ensuring residents were at all times protected from harm and not impacted by behaviours exhibited by their peers. This was a repeat inspection finding that was not satisfactorily addressed.

The next two sections of this report will discuss the findings of this inspection in more detail, the governance and management arrangements in place and how these ensured or not the appropriateness, quality and safety of the service provided to residents.

Capacity and capability

The management structure was clear as were individual roles, responsibilities and reporting relationships. The provider was collecting and analysing data and knew itself that it was not providing the most appropriate or best possible quality service to all residents. For example, the staffing levels and arrangements referred to in the first section of this report. However, there were other matters that while identified and within the control of the provider to address were not, based on these inspection findings satisfactorily addressed.

The local management team currently consisted of the person in charge supported by a co-ordinator who was in turn supported by social care workers. It was evident that there was a shared objective of improving and providing each resident with an appropriate, safe quality service. However, a gap had arisen in the social care worker role that in the context of the overall responsibilities of each person participating in the management of the centre, limited the capacity to provide consistent day-to-day oversight of the service. This was evident for example in the findings of this inspection in relation to the oversight of fire safety and personal planning.

The provider had quality assurance systems that collected and analysed data. For example, the six-monthly reviews required by the regulations were completed on schedule. The most recent review completed in December 2022 captured the satisfactory progress made on the previous internal quality improvement plan but also matters that were outstanding and that needed to be addressed. For example, in relation to staffing levels and the review and update of personal plans. There was evidence of good oversight and analysis of incidents that had occurred. This was completed by the co-ordinator and the person in charge. However, progressing the actions that were identified for improvement was not consistent and required a more collaborative governance wide response.

The provider had since the last inspection allocated some additional staffing each day so that a resident had the support that they needed to safely access their community. The inspector noted that the resident embraced this opportunity as staff recorded in the daily notes how the resident actively asked for "the car". However, the provider itself acknowledged that it did not have the staffing levels or arrangements that the resident needed by day and by night.

Good oversight was maintained of staff attendance at training. However, staffing deficits had recently impacted on a staff members' ability to attend scheduled training.

Registration Regulation 8 (1)

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

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked fulltime and had the experience, skills and experience needed for the role. The person in charge had delegated the day-to-day management of the service to the coordinator. It was evident that the person in charge monitored this arrangement. The person in charge gave good guidance and support to the coordinator and had sound knowledge of where improvement was still needed in this service. The person in charge was aware that there was a management capacity issue in the management structure due to the gap in social care worker hours in one house. The person in charge progressed matters that were within their scope of responsibility to address.

Judgment: Compliant

Regulation 15: Staffing

The provider itself had identified that it did not have the staffing levels and arrangements in place to meet the assessed needs of one resident and the risks associated with those assessed needs. The provider had concluded that the resident needed staff on waking duty at night (the current arrangement was a staff member on sleepover duty) and, two staff members by day to support safe community access for the resident. The inspector was advised that it could be assumed by sleepover staff that they would be up each night in response to the residents direct care needs and 60 such occasions were reported in the last quarter of 2022. In response to previous high risk incidents that had occurred in the community two staff members were on duty each day for approximately three to five hours for the safety of the resident and staff while out and about in the community. However, these staffing arrangements were very structured and time-bound and constrained the choice and flexibility that the resident had to leave their home. The provider had an open high risk, an identified restriction on the residents routines and choices and, an active business case in this regard.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector reviewed and discussed the staff training matrix with the coordinator. Overall, the inspector noted that staff attendance at mandatory, required and

desired training was good and refresher training that was due was either planned or booked. The provider had also since the last HIQA inspection sourced external training for staff on the therapeutic management of behaviour and aggression. The coordinator described to the inspector how the learning from this training was included in the induction and shadowing of more recently recruited staff. The coordinator confirmed that a schedule of formal staff supervisions was in place for all grades of staff. Findings arising from this HIQA inspection were the impact of staffing levels on staff ability to attend scheduled training and, the failure to adequately update the residents plan so that it included practice and interventions described to the inspector. These deficits are addressed in those relevant regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider itself knew and acknowledged that this centre was not adequately resourced to meet the assessed needs of the residents and the living arrangements provided were not suited in the longer term. While the day-to-day management and oversight of the service was of a good standard and was resident focused the inspector was not assured based on these inspection findings that there was adequate capacity in the local management arrangements to ensure consistent oversight. For example, ensuring that staff could attend any scheduled training and, that there was consistent oversight of areas such as fire safety and medicines management. In addition, there were repeat inspection findings in relation to positive behaviour support and ensuring residents were safeguarded from all types of harm including harm from a peer. This did not provide assurance as to how the wider governance structure supported the person in charge to exercise their regulatory responsibilities.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The contract of care reviewed by the inspector was current. The contract outlined the facilities and services to be provided to the resident, details of any charges to be paid by the resident and how these were calculated. The contract was signed as agreed by a representative of the provider and the resident's representative as provided for in the regulations.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed and updated to reflect the changes made and planned for the service. For example, the number of residents that could be accommodated and changes that had been made to the purpose and function of some rooms.

Judgment: Compliant

Quality and safety

The actions taken by the provider since the last HIQA inspection had improved the quality and safety of the service. For example, one resident had transferred to another nearby service operated by the provider. This transfer provided the ground floor accommodation that was needed by the resident. This and other actions such as the diversion of staffing resources to support safe community access had reduced the level of risk that presented to resident and staff safety at the time of the last inspection. However, the provider acknowledged that it needed to take further action to ensure each resident was provided with the best possible service. These inspection findings confirmed this and also identified other failings that limited the quality and safety of the service.

For example, the inspector saw how one resident enjoyed the additional living space that had been provided since the last inspection. Other refurbishment works had been completed such as a complete upgrade of the main bathroom and the creation of a sensory garden that was used and enjoyed by one resident. Ultimately however, the design and layout of the house was not suited to the needs and abilities of the two residents living in the house.

For example, there was an ongoing requirement for environmental restrictions both to ensure the safety of one of these residents but also to segregate the main house from the annexed apartment. While much better oversight of the need for and the use of these restrictive practices was evidenced there were restrictive practices that emerged not as a last resort but because residents shared facilities such as the laundry and the garden. Staff said and a resident confirmed that they did not go in to the garden when their peer was present in the garden given the absence of compatibility between these two residents. There was a certain poignancy as the inspector noted how one resident observed the activity in the main house from the garden.

Since the last HIQA inspection the person in charge had sought training for the staff team to develop their skills and knowledge in responding to behaviour that was challenging and that also presented as a risk to resident and staff safety. The coordinator described increased staff confidence and effective strategies and

interventions that were used in daily practice. However, the inspector saw that this practice and these interventions were not adequately integrated into the plans that guided day-to-day behaviour support practice in the centre. Overall, the inspector was not assured appropriate arrangements were in place for supporting residents and the staff team where behaviours impacted on the quality and safety of the service and on the wellbeing of peers.

For example, an incidental finding of the last HIQA inspection was an open moderate risk for the risk of harm from a peer between two different residents living in another house. Based on the analysis of incidents completed by the coordinator and the person in charge and seen by the inspector on this inspection, this was not resolved. It was clearly written on records seen that incidents had occurred that were triggered by disruptive behaviours exhibited by a peer.

This did not provide assurance as to how the psychological and emotional wellbeing of this resident was safeguarded and protected from the harm caused by the actions of their peer. The inspector was advised that an external assessment of the compatibility of these two residents to live together had been commissioned. However, based on these and previous HIQA inspection findings there was a fundamental gap in the therapeutic support provided that did not maximise their potential or ability to live more compatibly together.

The overall level of risk that presented in the centre to resident and staff safety was reduced. For example, the relocation of one resident to a more suitable house eliminated the risk of a fall on the stairs. The coordinator and the person in charge worked together to review and analyse incidents that had occurred, their management and any learning or additional controls needed. The relevant risk assessments were reviewed and updated based on the findings of these reviews.

It was evident that fire safety was considered when the premises works were completed. For example, a door designed to contain fire and its products had been provided between the utility room and the new living room that was created for one resident. The house was fitted with equipment such as a fire detection and alarm system and emergency lighting and these were appropriately inspected and maintained. However, a review of the impact of restrictive interventions (a locked door) on possible escape routes and how this would be more effectively and safely managed was needed.

Regulation 11: Visits

Access to home and family and receiving visitors in each house was facilitated for each resident as appropriate to their circumstances.

Judgment: Compliant

Regulation 17: Premises

In one house the provider had reduced the number of residents and reconfigured the layout of the house to improve the space available to one resident. The provider had also extended and enhanced the security of the outdoor space. The inspector saw the benefit of this to the daily life of the resident and to the staff team given the better controls in place to mange risk. For example, a safe and secure area where the resident could enter and exit the service vehicle was available. The provider had also completed upgrading and general redecoration works. However, ultimately the design and layout of the house and the internal controls that were needed to manage risk were not suited to the needs and abilities of the two residents living in this house. Their needs and abilities were very different and they lived completely independently of each other each day. They had segregated areas of the house (one resident lived in an annexed apartment) but they still lived in proximity to one another and also shared facilities such as the utility and laundry area and, the rear garden. They did not access these areas at the same time. The reconfiguration of the purpose of some rooms also meant that the original downstairs living room was now the staff office and staff sleepover room as staff had to be in close proximity at night to the resident in the annexed apartment. Staff spoken with were of the view that this arrangement impacted on the homely and social dimension of the house. An alternative upstairs living room had been provided for the resident. However, the inspector noted that the storage space in this room was used for storing archived files, cleaning products and stocks of personal protective equipment (PPE). This detracted from primary purpose of the room as a recreational-living space for the resident.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The level of risk to resident and staff safety was reduced since the last HIQA inspection. There were still risks to be managed and at times the risk that presented was high and unpredictable. For example, there was a residual high risk associated with community access for one resident and for the day and night-time staffing levels and arrangements. The risk register reflected the risks presenting in the centre and risk assessments were reviewed and updated based on incidents that occurred and any findings from the review of incidents. Overall, there was better oversight and more consistent management of risk. This was completed by the coordinator and the person in charge. There was better clarity and better consistency in the use of controls. However, the issue arising from these inspection findings was the fact that where local risk management and assessment identified the need for additional controls to reduce risk to resident safety and quality of life these were not in place. For example, the need for additional staffing and further intervention to support behaviours of concern. This is addressed in the relevant

regulations.

Judgment: Compliant

Regulation 28: Fire precautions

Better day-to-day oversight of fire safety arrangements was needed. For example,the inspector saw that work to protect the space under the main stairs from the risk of fire was completed but the practice of storing flammable items in this space was again evident. There was a planned schedule of fire drills to be completed by staff members and residents. The records of the drills completed indicated that residents responded to the requirement to evacuate and one staff member could evacuate both residents. However, better arrangements were needed given the high level of restrictions in place to ensure that all possible escape routes that may be needed in the event of fire were readily available and accessible to residents and staff. For example, one fire door between the apartment and the main house was manually locked to manage other risks that presented. There was a note on the door advising as to where the key was located. The key was not available at that location when the inspector looked. There was an alternative exit from this room but this entered into the utility which was potentially a high risk area for possible fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Staff spoken with described to the inspector the daily care and support needs of a resident. Staff maintained good person centred daily support notes of the care and support provided to the resident in the house and while out and about in the community. The staff team recorded how the resident engaged or not with their plan However, the residents personal plan was disjointed and inconsistently updated with many of the updates undated. The plan did not include all of the resident's healthcare needs or reflect all clinical recommendations made such as a request to monitor the resident's daily fluid intake. There were a number of standalone protocols to guide staff. In summary, the assessment of needs and the personal plan required a comprehensive review and update.

Judgment: Substantially compliant

Regulation 6: Health care

Staff monitored resident health and wellbeing. The person in charge ensured that residents had access to their general practitioner (GP), psychiatrist, dentist and other services such as occupational therapy. Monitoring resident wellbeing included the review of any prescribed medicines. Staff monitored the impact and effectiveness of these medications and provided feedback as necessary to the relevant prescriber. In the context of residents needs and capacity the provision of healthcare was at times challenging for the resident and the staff team particularly if hospital based services were needed. There were plans and protocols in place to best support the resident to receive the care that they needed.

Judgment: Compliant

Regulation 7: Positive behavioural support

Based on what the inspector read and discussed the inspector was not assured adequate arrangements were in place for the provision of support to residents who exhibited behaviour that was a challenge to others including their peers. In its response to the previous HIQA compliance plan the provider stated that a referral had been sent for positive behavior review and support for a resident. On this inspection the inspector was again told that behaviours exhibited by one resident could and did act as a trigger for behaviours in their peer. The inspector reviewed records of the analysis of incidents that had occurred between these two residents in late 2022. That analysis clearly stated that there were incidents that had been "instigated" by the behaviours of their peer. The behaviours described in the records were disruptive, socially unacceptable behaviours. These behaviours greatly upset their peer and led to an escalation in their behaviour which the resident then found difficult to regulate. The impact on the resident was significant based on the records created by staff as the resident expressed responsive behaviours that were aggressive and threatening towards their peer and staff. The inspector was advised that there had been multi-disciplinary discussion and a review of the plan in place for the resident who responded to the triggering behaviours had been completed. However, the inspector was also advised that the triggering behaviours, their purpose and the residents understanding of the impact and consequences on their peer and the staff team had not been explored with that resident. The inspector was advised that there were no strategies or plans in place in relation to this triggering behaviour.

In addition, the inspector found that the plans and guidance in place for another resident were fragmented with three separate positive behaviour support records in place. These findings did not provide assurance of an integrated approach that guided staff practice and that ensured consistency so as to best support the resident.

Some restrictions were in place because of the shared nature of some facilities such as the garden and the utility room and the absence of compatibility between

residents.

Judgment: Not compliant

Regulation 8: Protection

Based on these and previous inspection findings the inspector was not assured that there was a solid understanding of and appropriate arrangements in place to protect residents from all forms of abuse including abuse by their peers. As stated above there were repeat inspection findings of how behaviours exhibited by one resident negatively impacted on another resident they lived with. Records seen stated that this resident became upset and aggressive and had difficulty regulating their emotions and their psychological wellbeing in response to the behaviours exhibited by their peer. Staff had recorded that while physical incidents had not occurred between the residents verbal aggression between them had been displayed.

Judgment: Not compliant

Regulation 9: Residents' rights

This service was person-centred and the person in charge and the staff team were strong and consistent advocates for measures for improving the quality and safety of the service for all residents. However, their were reported barriers to ensuring residents had the service and arrangements that were appropriate to their needs such as a suitable premises and suitable staffing levels and arrangements. The possible use of advocacy services as an additional support to hear and express the voice of the resident had not been explored.

Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	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	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for The Elms OSV-0004877

Inspection ID: MON-0035782

Date of inspection: 10/05/2023

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
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, by ensuring the following actions are completed:

• A business case has been submitted to the HSE since June 2022 for the provision of additional funding for one resident currently funded for full-time 1:1 supports; who, based on assessed level of needs/ risk, actually requires 2:1 supports for community access and waking night cover.
Most recent update on need for approval of business case submitted to HSE on 04/05/2023. Further update submitted on 23/05/2023 advising on outcome of this inspection, and continuing need for approval of business case.

• Risk assessment in place for this residents' community access and supports required relating to this risk and related to his staffing levels at night, escalated to senior management; accepted by SMT, and submitted to HSE with business case.

• Quarterly updates provided to HSE since June 2022, outlining ongoing need for additional resources due to resident's assessed need and level of risk.

• The PIC and PPIM will ensure that the current roster is reviewed fortnightly to ensure the resident is provided with the opportunity for community access daily, while awaiting the approval of additional funding to enhance supports.
[Complete fortnightly]

Anticipated date of implementation of appropriate level of supports (dependent on funding approval from HSE): 30/09/2023.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Assurances relating to the governance and management systems within the designated centre will be delivered as follows:
• Recruitment is in progress to cover the required SCW extended leave. The person recruited will be suitably skilled, experienced and qualified to fulfil the role. [Completion date: 30/08/2023]
• See action plan outlined under Regulation 15: Staffing, Regulation 17: Premises, Regulation 5: Individual Assessment & Personal Plan, Regulation 8: Protection & Regulation 7: Positive Behavioural Support for additional actions relating to this regulation.
• Coordinator will base in DC at least three times per week, to ensure appropriate level of day to day oversight and management of the DC.
• The provider will at all times going forward, 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. The governance system will clearly identify the lines of authority and accountability, will specify the roles and detail the responsibilities for all areas of service provision.

[Overall completion date linked with action plan relating to Staffing – 30/09/2023]

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider will 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. This will be ensured as follows:
• Items stored beneath the stairs on the day of inspection have been removed. [Complete]
• Items stored in one resident's recreational-living space will be removed [Completion date: 30/06/2023]

Two resident's incompatibility to remain sharing their current living environment will be actioned as follows:
• An alternative service location has been identified as a suitable home for one of the residents by the provider, based on his assessed need/ level of risk. Said service location is fully accessible. Service location is not currently available, but is expected to become available within the coming year. This individual's transfer will also be contingent on approval of required resources by the HSE.
[Anticipated completion date: 31/12/2023]
This move will be guided by a transition plan taking into account the resident's needs

and wishes.
• With regard to the introduction of any new residents to the DC, a compatibility assessment will be completed to ensure their compatibility with existing resident. Current interim measure of re-configuring rooms within one house (particularly re-configuration of sitting room to staff sleepover room), will be reverted following one resident's move to a more suitable living environment.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider shall make adequate arrangements for reviewing fire precautions. This will be ensured by:
• Works are in progress to replace the lock on the referenced fire door between the main house and apartment; with a lock that is thumb-turn on the main house side, and corresponding to the overall master-key of the property. This will allow staff to unlock the door from the apartment side, using the master-key they retain on their person in the event of an emergency evacuation being required. [Completion Date: 10/06/2023]
• Restrictive practice reviews going forward will include consideration towards impact of each restrictive practice on fire safety and evacuation. [Next review due: 30/07/2023]

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:
The provider will ensure compliance with Regulation 5: Individual Assessment & Personal Plan by:
• The Coordinator & PIC will ensure that a full comprehensive review of one resident's personal plan, is completed as a priority. This review will include the resident's healthcare and clinical recommendations.
o Resident's daily fluid intake is now being monitored, to provide requested information to clinical team. [Complete]
o An internal multi-disciplinary meeting will be arranged by the PIC to discuss the resident's assessed needs, to ensure a multi-disciplinary approach which is focused on progressing best possible service and outcomes for resident(s). This will be overseen and monitored by the PIC, and will be incorporated into his personal plan. [Completion date: 01/08/2023]
o Resident's health care plan and hospital passport will be reviewed to include learning from recent hospital admission, and to include a protocol to guide staff going forward to

prevent future reoccurrences. [Completion Date: 01/08/2023]
• Thereafter, the Coordinator will ensure that a full review of all resident's plans is carried out. [Completion date: 30/11/2023]
• Personal plans will be reviewed subsequently at least annually, or sooner if resident's circumstances change.
• Stand-alone protocols will be reviewed as part of the individual's overall PBSP review, as referenced below under Regulation 7.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour. This will be ensured as follows:
• For one resident:
o His PBSP will be comprehensively reviewed, to ensure an integrated approach to guide staff practice and ensure consistency of support. Current successful strategies and interventions will be incorporated into his PBSP. Stand-alone documents referenced in the report, will also be incorporated into his PBSP. [Completion date: 01/08/2023]
o As outlined above, a multi-disciplinary meeting will be arranged, where the resident's PBSP will be reviewed as part of his overall assessed needs. [Completion date: 01/08/2023]
• For resident, who is displaying behaviours which are triggering a response from his peer:
o A positive behavior support referral request will be re-sent to Principal Clinical Psychologist & PBS team for one resident who was previously declined this multidisciplinary intervention. Referral will specify request for support relating to the residents' possible triggering of responsive behaviours by their peer.
[Completion date for referral: 25/05/2023]
[Anticipated completion date of creation of PBSP/ strategies: 01/08/2023]
o See additional action below under Regulation 8: Protection.
• One additional resident's PBSP has been reviewed, where a review was required. Three observation dates are scheduled with the assigned PBS Specialist. [Completed]

In addition, with relation to restrictive practices in use:
• The next review of restrictive practice will include consideration towards impact of each restrictive practice on other residents. [Next review due: 30/07/2023]
• A review of a recent high-risk incident resulting in the use of physical holds will be carried out by the Coordinator, at upcoming refresher training [Completion date: 31/05/2023].

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The registered provider shall protect residents from all forms of abuse. This will be ensured by:
• An internal multi-disciplinary meeting will be arranged by the PIC to discuss the residents' respective needs (including PBS needs), overall compatibility within the DC (and each location within the DC) and the related risk to ensuring the protection and safety of each resident.
[Completion date: 01/08/2023]
• Coordinator will review incident reporting with the team at their next scheduled team meeting. This review will re-visit how to respond to and report incidents between peers, and will include a focus on emotional/ psychological abuse and its impact. [Completion date: 02/06/2023]

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights, by ensuring the following actions are taken:
• The Coordinator/ PIC on the resident's behalf, will seek representation for the resident from the National Advocacy Service, to make certain his voice is independently represented to ensure best possible quality of life for him and that he has the service and arrangements that are appropriate to his needs. [Completion Date: 01/08/2023]

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.	Not Compliant	Orange	30/09/2023
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	31/12/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	30/08/2023

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	30/09/2023
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	30/09/2023
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/07/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional,	Substantially Compliant	Yellow	01/08/2023

	of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
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, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/11/2023
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	01/08/2023
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour	Not Compliant	Orange	01/08/2023

	necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	01/08/2023
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.	Substantially Compliant	Yellow	01/08/2023