Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Mullingar Respite
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Announced
Date of inspection:	15 February 2022
Centre ID:	OSV-0006455
Fieldwork ID:	MON-0027581

About the designated centre

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

Mullingar Respite is a community respite house located on the outskirts of a busy town in Co Westmeath. The centre is a bungalow and has access to amenities, such as supermarkets, restaurants, and cafes. Services are provided from the designated centre to both male and female adults (over 18 years old) and male and female children (5-18 years old). Respite breaks are offered on a sequence of two weeks adults respite and one week's children's respite. (Children & adults are not facilitated to attend services together). The maximum occupancy for overnight support in the house is for 4 individuals. The building design is currently suitable for individuals with high support needs. There are four bedrooms in total and with one being en-suite and a large entrance hall with spacious corridors. A main bathroom is also provided with suitable fixtures and fittings to meet the assessed needs of the residents. There is an open plan kitchen and dining facility, utility room, bathroom facility and a suitably decorated sitting room. To the rear of the house is a garden with a patio area and there is also garden area to the front of the property. The centre is accessible and adapted to meet the assessed needs of all residents and is staffed on a 24/7 basis by a person in charge and team of both nursing and social care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 15 February 2022	09:20hrs to 17:30hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall from what the inspector was told and what was observed residents received a good quality of care and support in this centre. However, there were improvements required in relation to the statement of purpose, training and staff development, governance and management, notification of incidents, individualised assessment and personal plan, positive behaviour support, protection, premises, and risk management procedures. These areas are discussed further in the next two sections of the report.

The inspector had the opportunity to meet with four residents that attended the respite service. Residents with alternative communication methods, did not share their views with the inspector, and were observed at different times during the course of the inspection.

Two residents spoke to the inspector and said that the respite house was nice and staff were kind. They said they picked what they wanted to do for their respite break and picked what rooms they wanted to stay in. Another resident briefly spoke to the inspector and said they liked coming to respite.

At different times of the day residents went out for walks or drives and some went food shopping for the centre. Residents were observed to relax and watch television in different rooms and one completed some art. Another resident offered to help carry files on several occasions for the inspector to view as part of the inspection and later helped the centre staff with shredding some paperwork.

The house appeared clean and tidy. It had sufficient space for privacy and recreation for residents to use. There were jigsaws, games, DVDs, art supplies, and sensory objects available for use. Each resident had their own bedroom when attending the respite service and one room was en-suite. There were adequate storage facilities for their personal belongings and residents were welcome to bring in their own belongings to make their room feel more homely.

The property had a wraparound front and back garden. The front garden contained some raised vegetables beds, the residents had been supported to paint the boxes that contained the raised beds and also had helped to grow vegetables. The back garden contained a set of swings, a spider web swing, a picnic bench, a gazebo, and football goals for residents use.

As part of COVID-19 management in the centre the arrangements in place at the time of the inspection were that residents did not attend external day services while attending respite. From speaking to the person in charge this arrangement was under review at the time of inspection.

There were two staff on duty on the day of inspection. Staff spoken with demonstrated that they were knowledgeable on the residents' care and support

needs required. They were observed to engage in a manner that was friendly and attentive. Resident and staff interactions appeared to be relaxed.

The inspector had the opportunity to speak with four family representatives as they each arrived to the centre to drop off their family member. The inspector used this opportunity to express their views on the quality and safety of care their family members were receiving. All four representatives spoken with expressed that they were very happy with the service being provided. They believed that their family member was well cared for and that they liked attending the centre. They expressed that they felt comfortable that they could raise concerns if required. Some would love to avail of more respite breaks if the opportunity ever arose.

Also as part of this inspection process residents' view were sought through questionnaires provided by the Health Information and Quality Authority (HIQA). Feedback from the questionnaires returned was provided by way of family representatives and was extremely positive with some saying their family were always made feel welcome. When asked was there anything they would like to say about the staff, another family said they loved the interaction with all staff members and that their family member was treated like family.

As part of the annual review the provider had also given residents and their representatives the opportunity to give feedback on the service provided to them. Feedback received indicated that people were satisfied with the service and that there was a person centred approach provided by a professional and friendly team.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

Overall, the inspector found there were management systems in place to ensure safe quality care was being delivered to the residents. The centre was adequately resourced to meet the assessed needs of residents. There were some improvements required in relation to the statement of purpose, training and staff development, governance and management, and notification of incidents.

There was a statement of purpose available that was updated regularly however, it required some review and updating to reflect the current arrangements in place in the centre. The centers statement of purpose clearly stipulated that the service only opened Tuesday to Friday each week and only provided emergency respite breaks for people known to the respite service. However, from a review of the service provided the inspector found that during 2021 the respite service had operated some additional weekends to facilitate residents and on another occasion accepted an emergency admission of a person not known to the centre. This meant that the service was operating outside the organisation's own terms and conditions as set

out in their statement of purpose.

There was a defined management structure in place which included a newly appointed person in charge and a long standing deputy person in charge. The person in charge was employed in a full time capacity and had the experience and qualifications to fulfil the role. The person in charge was found to be responsive to the inspection process and aware of their legal remit to S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). For example, they were aware that they had to notify the Chief Inspector of Social Services (the Chief Inspector) with regard to any adverse incidents occurring in the centre, as required by the regulations. They were also aware that an annual review of the centre was required to be completed.

The provider had carried out an annual review of the quality and safety of the centre and there were arrangements for auditing of the centre carried out on the provider's behalf on a six-monthly basis. The annual review of the service had included consultation with residents and family representatives. From a review of the annual review and the six-monthly visits the inspector found that any actions identified had been followed up on or a quality improvement plan was in place with specific time frames. The audits had not identified many of the areas found by the inspector and therefore oversight practices weren't always adequate for the centre. The provider had self-identified that a review of the auditing process for each centre in the organisation would be beneficial for a more in-depth overview and had plans to implement this in 2022.

There were other local audits such as COVID-19, first aid box, vehicle checks, fire safety, and health and safety audits. The action identified from the previous HIQA inspection had been addressed by the time of this inspection.

From a review of the rosters the inspector saw that there was a planned and actual roster in place that accurately reflected the staffing arrangements in the centre and it was maintained by the person in charge. The inspector reviewed a sample of staff files and found that the provider had ensured that information required under Schedule 2 of the regulations was present for employees in order to ensure recruitment procedures were safe.

Staff had access to the majority of necessary training and development opportunities in order to carry out their roles effectively and to meet residents' assessed needs. Staff training included, fire safety training, safeguarding of vulnerable adults, children first training, medication management, and infection prevention and control trainings. However, at the time of inspection staff had not received training in positive behaviour support. Assurances were provided by a member of the senior management team that this training would take place the week after the inspection. One staff member required dysphagia training that was required to support some residents that attended the service. The staff member in question was knowledgeable in relation to residents' eating, drinking and swallowing supports required.

There were formalised supervision arrangements in place as per the organisation's policy and there were monthly staff meetings occurring in the centre. Staff spoken with said they felt supported and would be comfortable bringing matters of concern to the person in charge if required.

From a review of incidents that had occurred in the centre since the last inspection, the previous person in charge had not notified the Chief Inspector in line with the regulations when every adverse incident had occurred in the centre. The current person in charge retrospectively submitted the notification post inspection.

Regulation 14: Persons in charge

The person in charge was employed in a full time capacity and had the experience and qualifications to fulfil the role. The person in charge was found to be responsive to the inspection process and aware of their legal remit. For example, they were aware that they had to notify the Chief Inspector of Social Services (the Chief Inspector) with regard to any adverse incidents occurring in the centre, as required by the regulations. They were also aware that an annual review of the centre was required to be completed.

Judgment: Compliant

Regulation 15: Staffing

The inspector saw from a review of the rosters that there was a planned and actual roster in place that accurately reflected the staffing arrangements in the centre and it was maintained by the person in charge. From a sample of staff files reviewed it was found that the provider had ensured that information required under Schedule 2 of the regulations was present for employees in order to ensure recruitment procedures were safe.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to the majority of necessary training and development opportunities in order to carry out their roles effectively and to meet residents' assessed needs. Staff training included, fire safety training, safeguarding of vulnerable adults, children first training, medication management, and infection prevention and control trainings.

However, at the time of inspection staff had not received training in positive behaviour support and one staff required dysphagia training that was required to support some residents that attended the service.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a defined management structure in place which included a newly appointed person in charge and a long standing deputy person in charge. The provider had carried out an annual review of the quality and safety of the centre and there were arrangements for auditing of the centre carried out on the provider's behalf on a six-monthly basis. The annual review of the service had included consultation with residents and family representatives. Any actions identified from audits had been followed up on or a quality improvement plan was in place with specific time frames.

Improvements were required to oversight practices as the audits had not identified many of the areas found by the inspector.

The provider had self-identified that a review of the auditing process for each centre in the organisation would be beneficial for a more in-depth overview and had plans to implement this in 2022.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

It was found that during 2021 the respite service had operated some additional weekends to facilitate residents and on another occasion accepted an emergency admission of a person not known to the centre. This meant that the service was operating outside the organisation's own terms and conditions as set in their statement of purpose, which clearly stipulated that the service was only open Tuesday to Friday each week and only provided emergency respite breaks for people known to the respite service.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of incidents that had occurred in the centre since the last inspection,

the previous person in charge had not notified the Chief Inspector in line with the regulations when every adverse incident had occurred in the centre. The person in charge retrospectively submitted the notification post inspection.

Judgment: Substantially compliant

Quality and safety

Overall, residents in this centre were in receipt of good quality care and supports that were individualised and focused on their needs. However, some improvements were required in relation to individualised assessment and personal plan, positive behaviour support, protection, premises and risk management procedures.

There were arrangements in place for on-going assessments of residents needs with input from allied healthcare professionals as appropriate. There were personal plans in place for the majority of identified needs and these included plans to support residents with specific health care needs and their communication. However, some goals in place for residents were not very meaningful. For example, to go for drives or undertake shredding.

From a sample of residents' files viewed no official planning meeting reviews took place in 2021 although family input was sought with regard to the resident's assessment of need prior to attending for their respite stay and plans had been reviewed by staff on an annual basis. The current person in charge had self-identified that a complete overview of residents' files and in particular personal plans was required and this was reflected in the annual review.

There were healthcare plans in place for the majority of residents as required to support them such as asthma management, epilepsy care plans, and emergency medication protocols. However, an eating, drinking and swallowing plan required for one resident was not present.

Residents were supported by their families to attend any healthcare appointments and referrals. The person in charge said the centre would support individuals to attend a general practitioner (G.P) and facilitate allied healthcare professional assessments at the centre if required while residents were on a respite break.

The inspector reviewed the arrangement in place to support residents' positive behaviour support needs. Behaviours that challenge were minimal in this centre however, staff had not received training in the management of behaviour that is challenging including de-escalation and intervention techniques. This is being dealt with under regulation 16: training and development.

Residents had access to a behavioural support specialist to support them to manage behaviour positively if required. There was a positive behaviour support plan in place for one resident to guide staff as to how best to support them and staff spoken with

were familiar with the strategies within the plan. However, some other resident's risk assessments referenced reactive and proactive strategies in order to support them with their identified positive behaviour support needs although no formal documented plans that contained these strategies were in place for these residents. Staff spoken with were familiar with residents care and support requirements.

While there were restrictive practices in place, these were assessed as clinically necessary for residents' safety, were subject to a review by the organisation's restrictive practice committee every three months. There was evidence to show that consent had been sought from family representatives. Restrictions in place included lapbelts for use when residents were in their wheelchairs to prevent them falling and the chemical press in the centre was locked at all times when not in use.

There were arrangements in place to protect residents from the risk of abuse. There was a safeguarding policy and staff were appropriately trained. There were systems in place to safeguard residents' finances whereby staff counted and signed off on the finances upon arrival, departure and daily while the resident stayed in respite. Residents had intimate care plans to guide staff on how best to support them and inform staff of their preferences. There had been one incident of a peer to peer negative interaction in 2021 and staff had taken appropriate action at the time to safeguard those involved. While the previous person in charge had reviewed the resident's positive behaviour support plan in light of the incident they had failed to implement a formal safeguarding plan in relation to the other resident involved in the incident.

The inspector found that there were adequate systems in place to promote residents' rights. These included, weekly house meetings, picture schedule boards, and choice boards were on display. Residents spoken with said they felt they had choice of what they ate and what activities they were involved with while in respite.

There was a residents' guide prepared and a copy available to each resident that contained all the required information as set out in the regulations.

From a walkabout of the centre the inspector found the house to be spacious, tastefully decorated and adequate to meet the needs of the residents. There were some areas that required attention, for example, some areas required repainting and lampshades were required for each room to ensure a more homely feel. There was some slight mildew observed in one area.

Risk management arrangements ensured that for the most part risks were identified, monitored and regularly reviewed. There was a policy on risk management available and the centre had a recently reviewed risk register in place. The inspector observed that the centre's vehicle had been serviced, was insured and had an up-to-date national car test (NCT). Equipment provided by the centre used to support residents were all serviced within the last year. There was a safety statement in place which discussed Legionnaires' disease however, the centre had not been tested for this after reopening the centre. The centre had been closed for a number of months in 2020 and no alternative arrangements for flushing the water system had been put in place.

Each resident had a number of individual risk assessments so as to support their overall safety and wellbeing. However, some residents required a risk assessment in place for potential of choking but this was not in place. Some control measures recorded in other risk assessments were no longer applicable and other control measures mentioned in some risk assessments were not actually in place.

The inspector reviewed arrangements in relation to infection control management in the centre. There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19, with a contingency plan in place which included a staffing contingency and isolation plan for residents if required. Staff had been provided with relevant infection prevention and control trainings. Adequate supplies of personal protective equipment (PPE) were available in the centre and staff were observed using it in line with national guidelines. For example, masks were worn by staff at all times due to social distancing not being possible to maintain in the centre. There were adequate hand-washing facilities and hand sanitising gels available throughout the centre. There was a colour-coded system in place for food preparation and cleaning.

There were fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which were regularly serviced. Staff had received training in fire safety and there were fire evacuation plans in place for residents that were recently reviewed. Fire evacuation drills had been conducted using minimum staffing levels to ensure all residents could be evacuated and completed using different scenarios. A staff member and resident spoken were familiar with the procedure to be taken in the event of a fire.

Regulation 17: Premises

From a walkabout of the centre the inspector found the house to be spacious, tastefully decorated and adequate to meet the needs of the residents. There were some areas that required attention, for example, some areas required repainting as the paint was scuffed and lampshades were required for each room to ensure a more homely feel. There was some slight mildew observed in one area of one bedroom. The person in charge had arranged for the mildew to be cleaned prior to the end of the inspection.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide prepared and a copy available to each resident that contained all the required information as set out in the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

The centre had not been tested for Legionnaires' disease after it reopened towards the end 2020 after being closed for a number of months. No alternative arrangements for flushing the water system had been put in place.

Each resident had a number of individual risk assessments so as to support their overall safety and wellbeing. However, some residents required a risk assessment in place for the potential of choking but this was not in place, some control measures recorded were no longer applicable and other control measures mentioned were not actually in place.

One resident required a risk assessment with regard to their behaviours that require support.

Judgment: Not compliant

Regulation 27: Protection against infection

There were arrangements in place to control infection control risks in the centre and also in relation to COVID-19. There was a contingency plan in place which included a staffing contingency and isolation plan for residents if required. Staff had been provided with relevant infection prevention and control trainings. There were adequate supplies of personal protective equipment (PPE) were available in the centre and staff were observed using it in line with national guidelines. For example, masks were worn by staff at all times due to social distancing not being possible to maintain in the centre. There were adequate hand-washing facilities and hand sanitising gels available throughout the centre. There was a colour-coded system in place for food preparation and cleaning.

Judgment: Compliant

Regulation 28: Fire precautions

There were fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which were regularly serviced. Staff had received training in fire safety and there were fire evacuation plans in place for residents that were recently reviewed. Fire evacuation drills had been conducted using minimum staffing levels to ensure all residents could

be evacuated and completed using different scenarios. A staff member and resident spoken were familiar with the procedure to be taken in the event of a fire.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were personal plans in place for the majority of residents' assessed needs. However, one resident required an eating, drinking and swallowing plan which was not in place.

No official planning meeting reviews took place in 2021 for residents however, family input was provided with regard to the resident's assessment of need prior to attending for each of their respite stays and plans had been reviewed by staff on an annual basis.

Some goals identified for residents were not very meaningful such as to shred paper or go for a drive.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported by their families to attend any healthcare appointments and referrals. The person in charge said the centre would support individuals to attend a general practitioner (G.P) and facilitate allied healthcare professional assessments at the centre if required while on a respite break.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were restrictive practices in place, these were assessed as clinically necessary for residents' safety, were subject to a review by the organisation’s restrictive practice committee every three months. There was evidence to show that consent had been sought from family representatives. Residents had access to a behavioural support specialist to support them to manage behaviour positively if required. There was a positive behaviour support plan in place for one resident to guide staff as to how best to support them and staff spoken with were familiar with the strategies within the plan. Staff required positive behaviour support training and this is being dealt with under regulation 16: training and staff development. Behaviours that

challenge were minimal in this centre however no positive behaviour support plans were in place for some residents with identified support requirements in this area as identified by the provider. Staff spoken with were familiar with residents care and support requirements.

Judgment: Substantially compliant

Regulation 8: Protection

There was a safeguarding policy and staff were appropriately trained. There were systems in place to safeguard residents' finances whereby staff counted and signed off on the finances at different durations of the resident's stay. Residents had intimate care plans to guide staff on how best to support them and inform staff of their preferences. While staff had taken appropriate actions to safeguard to resident after an incident in 2021, no formal safeguarding plan had been implemented for the individual.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There were adequate systems in place to promote residents' rights such as, weekly house meetings, picture schedule boards, and choice boards were on display. Residents spoken with said they felt they had choice of what they ate and what activities they were involved with while in respite.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mullingar Respite OSV-0006455

Inspection ID: MON-0027581

Date of inspection: 15/02/2022

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Person in Charge will continue to ensure that staff have access to appropriate training, including refresher training, as part of continuous professional development programme.

Since the inspection, staff have been provided with Positive Behaviour Support training to include the following;

1) Autism Awareness
2) De-escalation Strategies
3) Environmental / Low Arousal Approaches

Staff have completed Dysphagia training on HSEland and the Person in Charge has arranged for bespoke training with Speech & Language Therapist which will include IDDSI Framework explanation and interactive session with full assistance support, scheduled 28.03.2022.

Date: 28.03.2022

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The audit process has been reviewed and improved to add value and lead to improved organisational processes to ensure that the governance and quality assurance process is more robust and effective.
The internal audits will be completed by the PPIM (Area Director) going forward.

Compliant Date: 30th June 2022

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose will be updated to include additional weekends facilitated in Respite.

The statement of Purpose has been fully reviewed to ensure Respite Service operates within the parameters set down in the Statement of Purpose.

The statement of purpose is reviewed at intervals of not less than one year.

The Statement of purpose is available to residents and their representatives.

The updated Statement of Purpose has been sent to the Inspector.

Compliant Date: 15th March 2022

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The person in charge will review all accidents incidents and ABC form as and when arise to ensure all safeguarding incidents are identified and notified to chief inspector.

All notifications are currently up to date, and retrospective notification submitted 16.02.2022 as requested.

Compliant Date: 16.02.2022

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure a good state of repair is achieved internally in the designated centre; The Person in Charge has contacted the General Operations manager, to schedule internal painting and decorating.

Due to the current pandemic, a number of homely items were removed from bedrooms on advice of infection control specialists. These will now be replaced in order to ensure a homely environment for individuals availing of Respite.

Compliant: 14th March 2022

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk management and implementation of risk controls were identified as a priority area of work for the newly appointed management team.

A review of individual's risk assessments reviewed and updated accordingly to ensure appropriate healthcare needs and behaviours which require support are detailed and appropriate control measures in place.

The designated centre was tested for legionnaires disease on 24.02.2022. A water sample was taken and sample passed the Legionella test. A Legionella Risk Assessment was completed on the 07.03.2022.

The Person in Charge has familiarised themselves with the HSE document 'National Guidelines for the Control of Legionellosis in Ireland' and will inform staff at team meeting.

Compliant Date: 11.03.2022

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:
In order to comply with Regulation 5 the Person in Charge will arrange for;
1. A review of all personal plans to ensure appropriate healthcare needs are detailed, having regard to each resident personal plan.
2. The Person in Charge will arrange formal review meetings of each individual's personal plan of all personal plans.

Compliant: 31st August 2022

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In consultation with the Behavior support team the local manager will ensure the review of the Behavior support plan which will include the following:

1. A review meeting will take place of the required Therapeutic interventions that are implemented, with the informed consent of each resident or his or her representative.
2. The plan will include up to date knowledge of the resident, along with proactive and reactive strategies to support staff in responding to behaviors that challenge and to assist individuals to manage their own behaviors.

Compliant: 7th March 2022

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
- Each resident is assisted and supported to develop the knowledge, self-awareness and skills needed for self – care and protection. The register provider protects all residents from all forms of abuse.
- Staff team complete ABC's following all incidences of behaviours of concern & submit to Person in Charge and Positive Behaviour Support team to aid the reformulating of the individuals Positive Behaviour Support Plan.
- Incident reports are submitted to the Person in Charge and Preliminary Screening undertaken & referral to Safeguarding Protection Team if deemed necessary on consultation with Designated Liaison Officer.
- Safeguarding Plans will be developed as required to ensure all individuals safety whilst availing of Respite.
- Concern identified by inspector on date of inspection was reported to Safeguarding team. Safeguarding plan developed and put in place on the 14.03.2022
Compliant Date: 14.03.2022

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 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	28/03/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	14/03/2022
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	Substantially Compliant	Yellow	30/06/2022

	monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	11/03/2022
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	15/03/2022
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Substantially Compliant	Yellow	16/02/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs,	Substantially Compliant	Yellow	31/08/2022

	as assessed in accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/08/2022
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	31/08/2022
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	07/03/2022

Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	14/03/2022