Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre: The Sycamores
Name of provider: S O S Kilkenny Company Limited by Guarantee
Address of centre: Kilkenny
Type of inspection: Unannounced
Date of inspection: 29 August 2018
Centre ID: OSV-0001875
Fieldwork ID: MON-0022438
About the designated centre

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

This centre comprises of two detached houses both in close proximity to Kilkenny city. At the time of this inspection the centre was accommodating 17 adults with disabilities (both male and female). Many residents have additional significant support needs as some are living with age related illnesses such as dementia, Alzheimer's disease, Parkinson's disease and kidney disease. Other residents present with conditions such as diabetes, visual impairment and epilepsy. Because of the significant level of support the residents require, the centre is staffed by a team of nurses, social care leaders, social care workers and care assistants. There is also a qualified person in charge in situ who is supported by an experienced and qualified team leader. Carer and support is provided to the residents on a 24/7 basis. Residents are supported to enjoy best possible health and have regular (or as required) access to a team of allied health care professionals to include GP services, dentists, chiropodists, speech and language therapists and mental health professionals. Hospital appointments are also facilitated as required. Residents are supported to have a meaningful day as there are a range of stimulating activities and social outings made available to them each day. Each resident has their own bedroom (some en suite) and they are decorated to their individual style and preference. Communal facilities include sittings rooms, dining areas, kitchens and a relaxation area. Private, well maintained and furnished garden areas are also accessible to the residents.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>08/02/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>17</td>
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</tbody>
</table>
How we inspect

To prepare for this inspection the inspector or 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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 August 2018</td>
<td>11:00hrs to 17:30hrs</td>
<td>Raymond Lynch</td>
<td>Lead</td>
</tr>
</tbody>
</table>
Views of people who use the service

The inspector met and spoke with nine of the residents that avail of this service. Residents reported that in general they were very happy with the service provided and they got on very well with management and staff. It was observed that residents were very relaxed in the company of all staff members and staff interacted with them in a warm, caring and professional manner. Residents spoke with the inspector about things they like to do and places they like to go. The inspector observed that the hobbies of interest and social activity preferences of each resident was being facilitated in the centre. For the most part, residents appeared content in this centre, they were very relaxed in the company of staff and reported to the inspector that they were happy living there.

Capacity and capability

For the most part, residents appeared happy and content in this centre and staff were observed to be very supportive and responsive in meeting their individual needs. However, the governance and management arrangements required review as they were not responding effectively to some issues which were known to the provider and which were impacting negatively on residents. The provider has not ensured that the physical layout of the centre was appropriate in meeting the assessed needs of one of the residents.

The centre had a clearly defined management structure in place as there was an experienced person in charge in situ who was supported in her role by a qualified and experienced team leader.

The person in charge and team leader were qualified nursing professionals and provided good leadership and support to their team. They ensured that staffing resources were channelled appropriately so as to meet the individual needs of each resident. They also ensured staff were appropriately qualified and supported so as they had the required skills to provide a person centred and responsive service to the residents.

Of the staff spoken with the inspector was assured that they had the skills, experience and knowledge to support the residents in a safe and effective way. Most held third level qualifications and all had undertaken a suite of in-service training courses to include safeguarding, fire training, manual handling and basic lifesaving skills. This meant they had the skills necessary to respond to the needs of the residents in a consistent and capable manner.
However, the overall governance and management arrangements required review as the physical layout of the centre was not appropriate in meeting some of the assessed needs of one resident. While the centre was a warm and welcoming environment, it was busy and there was inadequate communal space to support all residents. Some residents were also in receipt of their day service from the house which increased these space pressures.

One resident did not respond well to this environment and could present with behaviours of concern, which impacted negatively on a number of other residents. This issue was further compounded due to the fact there was inadequate communal space in the centre. While management and staff tried to manage this situation with the resources made available to them, it remained an ongoing issue at the time of this inspection.

It was also observed that the auditing and monitoring process required review. The six monthly audits and an annual review of the safety and quality of care provided a comprehensive overview of the service, where it was doing well and where it was challenged.

However, these documents were not available in one of the houses that comprised the centre, some of the actions arising from the audits had no time frame identified for their implementation and other actions had not been addressed adequately. For example, a number of audits carried out in 2018 identified the need for a second sitting room in one of the houses that comprised the centre. However an appropriate management plan was not in place to respond to this identified area for improvement.

Issues were also identified with the transport arrangements in place in the centre. In one house, a resident with a significant physical disability only had access to a suitable mode of transport three days a week. This meant that the resident's social activities were curtailed to these specific days and time frames. In the other house the bus was (at times) being used as an intervention to manage behaviours of concern. This meant that when the bus was in use with one resident as a means to de-escalate their behaviour (the resident in question liked bus outings), it was not available to support other residents access recreational and community as detailed in the centres Statement of Purpose.

There were systems in place to ensure that the residents’ voice was heard in the centre and where required, residents were supported to make a complaint. Where a complaint was made, it was logged and recorded. However, some complaints remained on-going due to compatibility issues between some of the residents as identified above.

Overall, from speaking with residents, management and staff during the course of this inspection, the inspector was assured that for the most part the residents were happy in this centre and staff supported them in a warm, friendly and professional manner. However, the layout of the premises was not conducive in meeting the assessed needs of one resident which was impacting negatively on a number of other residents who lived in this centre. The response of the provider to addressing
identified areas for improvement was not always effective.

**Regulation 15: Staffing**

At the time of this inspection, the inspector was satisfied that there were appropriate staff numbers and skill mix in place to meet the needs of residents. Staff were also observed to interact with the residents in a warm, friendly and professional manner and knew the needs of the residents very well.

**Judgment:** Compliant

**Regulation 16: Training and staff development**

Staff were provided with the required training so as to provide a safe and effective service to the residents. For example, staff had training in Safeguarding of Vulnerable Adults, Safe Administration of Medication and Positive Behavioural Support.

From speaking with three staff members over the course of this inspection, the inspector was assured they had the skills and knowledge necessary to support the residents and meet their assessed needs.

There were some gaps identified with regard to refresher training however, the team leader was aware of this and had a plan of action in place to address it.

**Judgment:** Substantially compliant

**Regulation 23: Governance and management**

While the quality of care and experience of the residents was being monitored and evaluated on an ongoing basis (via auditing, annual reviews and review of complaints received), a number of issues were impacting negatively on the quality of service being delivered to the residents. This was due to compatibility issues between some residents and the layout of the premises not being conducive in meeting the needs of one resident in particular.

The centre was also being monitored and audited accordingly however, some actions arising from audits had no time line for implementation and other actions (as
above) remained ongoing and had not been effectively addressed by the management systems.

Judgment: Not compliant

**Regulation 31: Notification of incidents**

For the most part the centre was reporting notifiable events to HIQA as required however, the inspector observed that some incidents involving peer to peer altercations had not been reported.

Judgment: Substantially compliant

**Regulation 34: Complaints procedure**

The provider was listening to and acting on residents' complaints. The inspector reviewed the complaints policy and found that it met the requirements of the Regulations. In addition the complaints procedures were available to the residents in an easy to read format where required

There was a logging system in place to record complaints, which included the nature of the complaint, how it would be addressed and if it was addressed to the satisfaction of the complainant. From reading a sample of documentation, the inspector saw that complaints were being recorded and responded to.

Some complaints remained on-going at the time of this inspection however, this issue was addressed under Regulation 23: Governance and Management.

Judgment: Compliant

**Quality and safety**

Residents were supported to have meaningful and active lives in their community and their significant healthcare needs were being comprehensively provided for. However, while the quality and safety of care provided to the residents was being monitored, the issues as identified in part one of this report, (compatibility of residents and layout of the premises) were impacting negatively on the quality of service delivered to a number of residents living in this centre.

Another issue was identified with regard to fire safety however, the management of
the centre were aware of this issue and had a plan of action in place to address it at the time of inspection.

The individual social care needs of residents were being supported and encouraged. From viewing a small sample of files and from speaking with staff members, the inspectors saw that the residents were being supported to maintain links with their families, community and enjoy best possible health. Residents were being supported engage in hobbies and activities of their choosing and interest and to frequent local community based amenities such as shops, beauticians, pubs, restaurants and library.

A minor issues was identified with the recording of documentation of some social care goals however, the inspector saw that this issue was identified in the auditing process and would be addressed.

Residents were supported with their health care needs (which were significant). Regular and as required access to a range of allied health care professionals also formed part of the service provided. The inspector saw that residents had regular (or as required) access to a GP, dentist, chiropodist and a speech and language therapist. Hospital appointments were facilitated as required and care plans were in place to support residents with conditions such as diabetes, epilepsy Parkinson’s disease and visual impairment. These plans helped to ensure that staff provided consistent care in line with the recommendations and advice of the health care professionals.

Residents were also supported to enjoy best possible mental health and where required had access to a range of mental health professionals such as a behavioural support specialist and psychologist. It was also observed that staff had training in positive behavioural support techniques so as they had the skills required to support residents in a professional and calm manner if or when required.

However, the inspector saw that at times, it was difficult to meet the assessed psychological needs of one resident (as recorded in their positive behavioural support plan) due to the layout of the premises and environmental issues. This was having a negative impact on the quality of life of this resident. It was also observed that the behaviours in which this client engaged in (due to the unsuitability of the physical environment) was at times, impacting negatively on the quality of life of some of the other residents.

Some restrictive practices were in use in the centre however, the inspector observed that they were only in use to keep residents safe and/or enable to better participate in social activities.

While this remained an on-going issue at the time of this inspection, residents reported to the inspector that they were generally happy in the centre and it was observed that they were very much at ease in the presence of staff and could speak to staff about any issues they may have. Residents were informed of their rights, knew how to make a complaint and staff had training in safeguarding of vulnerable adults. From speaking with three staff members the inspector was assured that they
had the skills and knowledge to support the residents and advocate on their behalf.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. For example, where a resident may be at risk in the community, safeguards were put in place to promote their safety. This ensured that the resident remained connected to their community and could engage in regular social activities in a safe and dignified manner.

However, some risk assessments required review as they were not adequately descriptive of some of the measures in place to keep residents safe. For example, one resident was at risk of falling. Staff were aware of this issue and had a number of measures in place to mitigate this risk. However, these measures were not recorded on the residents falls risk assessment.

There were systems in place to ensure all fire fighting equipment was serviced annually. A sample of documentation informed the inspector that staff undertook regular and as required checks on all fire fighting equipment and where required, reported any issues or faults. However, it was observed that the emergency evacuations required review in one house that comprised the centre. Management were aware of this issue, had plans of action in place to address it and provided written assurances to the inspector that it would be addressed as a matter of urgency.

There were policies and procedures in place for the safe ordering, storing, administration and disposal of medicines which met the requirements of the Regulations and any staff member that administered medication were trained to so.

Overall residents reported to the inspector that there were happy in this centre and were very well supported by staff and their healthcare needs (which were diverse and significant) were being comprehensively provided for. However, the environment was not conducive in meeting the assessed psychological needs of one resident and this was impacting negatively on a number of residents living in this centre.

Regulation 17: Premises

The layout and design of the premises were not conducive in meeting the assessed needs of one resident. There was also inadequate communal accommodation in one house that comprised this centre

Judgment: Not compliant
Regulation 26: Risk management procedures

There was a risk register in place in the centre and each resident had on a file a number of individual risk assessments. However, some areas of risk assessment required review as they were not adequately descriptive of the measures in place that were keeping residents safe.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place to ensure fire fighting equipment was serviced as required by the regulations. Staff also undertook regular checks on all fire fighting equipment in the centre. An issue with regard to the emergency evacuation procedures was identified in one house that comprises the centre. While management and staff were aware of this and provided written assurances following the inspection that this issue would be promptly addressed, this indicated that evacuation procedures required review to ensure they were safe.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that the medication management policies and procedures were satisfactory and safe.

The medication policy which was a comprehensive document and gave clear guidance to staff on areas such as medication administration, medications requiring strict controls, ordering, dispensing, storage, administration and disposal of medications.

All medicines were securely stored in a secured unit in the centre and any staff member who administered medication was trained to do so.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan
There were policies and procedures in place on the individualised planning process. Residents were being supported to maintain links with their community and family contact was being provided for. Some residents also had access to day service facilities where they engaged in activities and hobbies that were meaningful to them. A documentation issue with regard to the recording and upkeep of some residents daily activities and personal plans was identified in this inspection.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector was satisfied that residents health needs were being comprehensively provided for with appropriate input from allied healthcare professionals as and when required.

Residents also had regular to GP services, their medication requirements were being regularly reviewed and hospital appointments were being supported and facilitated as and when required.

Residents (where required) also had access to a range of mental health professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required, residents had access to a range of multi-disciplinary mental health supports to include a behavioural support specialist and psychiatry supports. Staff also had received specific training in positive behavioural support.

There were some restrictive practices in use in the centre. However, they were being reviewed as required and were only in use to promote the residents safety and/or enable residents to participate in activities safely.

However, the environment was not conducive in meeting the assessed psychological needs of one resident. The service was aware of this issue, it was highlighted in the residents positive behavioural support plan and staff were trying to manage the situation as best they could. However, because the environment was a significant trigger for this resident, staff working in the centre were not always in a position to alleviate the cause of the residents challenging behaviour.
Judgment: Not compliant
## Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 31: Notification of incidents</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 29: Medicines and pharmaceutical services</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Not compliant</td>
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</table>
Compliance Plan for The Sycamores OSV-0001875

Inspection ID: MON-0022438

Date of inspection: 29/08/2018

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:**

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tbody>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially Compliant</td>
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</tbody>
</table>

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

**Staff training and refresher training continues as per roster. The main areas of focus include Manual Handling/ Patient Moving, Fire Safety Module 2, Positive Behaviour Support and Safe and Responsible Management and administration of medication training.**

**Next Training dates available;**
**Relevant staff will be rostered on Refresher for Safe and Responsible Management and administration of medication training on 11/ 12/ 18; on Manual Handling (19/ 11/ 18) and on Fire Safety (20/ 11/ 18).**
**Positive Behavior Support; 23 staff are fully compliant and have received training and all remaining staff will be trained on next available date.**

<table>
<thead>
<tr>
<th>Regulation 23: Governance and management</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 23: Governance and management:
Issue 1 Highlighted:
There is a plan in place to transfer the service user identified as someone who was not responding to their environment. It is proposed that this transfer will take place on the 12/11/18. This will facilitate usage of space as a second communal space, such as sitting room/relaxation room. The transfer will provide the service user in question an environment whereby their needs may be met in a more suitable environment with specific supports in place. Work continues on transition plans with a view to the transfer taking place on 12/11/18. Additional information has been submitted to HIQA re: application to register on the 26/10/18.

Issue 2 Highlighted:
Auditing and Monitoring: 6 monthly audits and annual reviews are now available in all houses. Team meetings were used as a forum to discuss same. Team leaders now specifically identify staff to complete actions highlighted and have a timeline identified for each action.

Issue 3: Highlighted:
Transport: Transport will be provided for the service user who is transferring to another center on the 12/11/18. This will facilitate support for other residents to use the existing transport to access recreational and community activities as detailed in the Statement of Purpose.
It was also identified that a resident with a significant disability only has access to suitable transport 3 days a week. Staff continue to arrange outings around this timetable. The organization continues to review its transport resources at Senior Management Team level and is looking at suitable vehicles which will meet the specific needs of service users. There is no specific date identified as to when this issue will be resolved but in the interim staff continue to advocate on behalf of the service user and utilize the transport when it is available (outside the 3 specific days) as well as the allocated days.

Issue 4 Highlighted:
Complaints: Some complaints remained ongoing at the time of inspection due to compatibility issues between residents. It is anticipated that this will be resolved following the transfer of a service user to another center on the 12/11/18. Complaints logged at present will then be closed. (Following transfer).

<table>
<thead>
<tr>
<th>Regulation 31: Notification of incidents</th>
<th>Substantially Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</td>
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</tbody>
</table>
All allegations of suspected or confirmed abuse including incidents involving peer to peer altercations will be reported on a NFO6 form. All team leaders are now aware that this should be completed in conjunction with an internal notification form and other relevant safeguarding documentation. They will complete this process each time there is a suspicion of any type of abuse. Refresher training on safeguarding will be organized for team leaders/managers date not confirmed at this time. Email sent to All managers. Going forward will be on agenda for team meetings.

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 17: Premises:</td>
<td></td>
</tr>
<tr>
<td>The resident identified in the report will be transferring to another center on 12/11/18. Additional information has been submitted to HIQA re: application to register on the 26/10/18. This will facilitate usage of space as a second communal space, such as sitting room/relaxation room.</td>
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<table>
<thead>
<tr>
<th>Regulation 26: Risk management procedures</th>
<th>Substantially Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</td>
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</tr>
<tr>
<td>All Risk Assessments continue to be reviewed as necessary at least yearly. Risk Assessments identified as part of the inspection have been updated and reviewed. They now contain further information describing in more detail the measures in place to reduce risk of injury and harm. The level of detail required when reviewing and updating the risk assessments has been communicated to all team leaders. The risk assessments are signed off by the Person in Charge who is also aware of the level of detail required.</td>
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</table>
Regulation 28: Fire precautions  |  Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Unannounced fire evacuation took place 03/09/18. Arrangements in place to have regular evacuations. This will be arranged with team leader so that all staff have the opportunity to experience same. C.E.E.P and P.E.E.P. updated where necessary to reflect recommendations following unannounced fire evacuation. Assembly point previously located in back yard now relocated to front of building. Issues regarding pathways addressed. Building work completed. Ski Pads are ordered for relevant individuals. Expected delivery 2 weeks ordered 02/11/18. Pillow alert in place for one resident. Report on findings following evacuation on file. Actions identified and completed by identified staff. Ongoing refresher training continues in Fire Safety Module 2.

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:

Social care goals: Personal outcomes will be documented as part of daily notes and also reflected in individual activity sheets. Discussion with staff regarding what is or is not recorded and the importance of recording the activity highlighted at monthly team meeting (03/10/18). One service user was identified as not having their needs met due to the layout of the premises and environmental issues. They were also engaging in behaviors of concern at times impacting on others in a negative way. This service user has been identified to transfer to another center on the 12/11/18. As part of transition all personal documentation will be updated and completed. Transition Plans continue to be worked on and the Team Leader has identified key staff to work on same.
<table>
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<tr>
<th>Regulation 7: Positive behavioural support</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The resident referred to in the report will be transferring to another center on 12/11/18. Additional information has been submitted to HIQA re: application to register on the 26/10/18. The environment identified is smaller and quieter. This service user will move to the new designated center with staff support only with a view to sharing with a smaller group of people in the coming weeks. It is hoped the smaller group of service users (Max 4) will impact positively on this service user’s behaviour. The service user will continue to have access to a range of support such as the behavioural support specialist and staff identified to support the service user have completed training in positive behavioural support.
**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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>19/11/18 to 11/12/18</td>
</tr>
<tr>
<td>Regulation 17(1)(a)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>12/11/18</td>
</tr>
<tr>
<td>Regulation 23(1)(a)</td>
<td>The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>12/11/18</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance Status</td>
<td>Color</td>
<td>Date</td>
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<td>Regulation 23(1)(c)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>12/11/18</td>
</tr>
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<td>Regulation 23(1)(f)</td>
<td>The registered provider shall ensure that that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>01/09/18</td>
</tr>
<tr>
<td>Regulation 26(1)(b)</td>
<td>The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>07/11/19</td>
</tr>
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<td>Regulation 28(2)(b)(ii)</td>
<td>The registered provider shall make adequate arrangements for reviewing fire precautions.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>16/11/18</td>
</tr>
<tr>
<td>Regulation</td>
<td>The person in</td>
<td>Substantially</td>
<td>Yellow</td>
<td>09/11/18</td>
</tr>
<tr>
<td>Regulation 31(1)(f)</td>
<td>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.</td>
<td>Compliant</td>
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<td>Regulation 05(6)(c)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>06/11/18</td>
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<tr>
<td>Regulation 7(5)(a)</td>
<td>The person in charge 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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>12/11/18</td>
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</tbody>
</table>