Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	National Association of Housing for Visually Impaired
Name of provider:	National Association of Housing for Visually Impaired
Address of centre:	Co. Dublin
Type of inspection:	Short Notice Announced
Date of inspection:	18 June 2018
Centre ID:	OSV-0001938
Fieldwork ID:	MON-0024209

About the designated centre

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

This Residential Service is for vision impaired adults, both male and female, with additional disabilities. The centre can cater for 16 residents over the age of 18 years. The centre is staffed with three social care workers, and 20 care assistants along with the person in charge and service manager. The centre comprises of four houses which are close to local amenities such as shops, train stations, bus routes and churches. Day services are not provided. Residential care is provided across 24 hours with sleep over staff.

The following information outlines some additional data on this centre.

Current registration end date:	19/06/2021
Number of residents on the date of inspection:	16

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:

Date	Times of Inspection	Inspector	Role
18 June 2018	10:30hrs to 18:30hrs	Louise Renwick	Lead
18 June 2018	10:30hrs to 18:30hrs	Sinead Whitely	Support

Views of people who use the service

Inspectors met the majority of residents living in the centre over the course of the day, and spoke specifically with four residents about their experience of living in the centre. Residents had completed questionnaires in February 2018 at the time of the last inspection, which all reflected satisfaction with the centre.

Residents told inspectors that they liked the centre and the staff working with them. Residents spoke about some of the things they were working on in their lives. One resident told inspectors that soon they were moving from one house to another which they were happy about, as it meant they didn't have to share a room anymore.

Residents appeared content living in the centre and relaxed in their own home. Some residents said they liked who they lived with.

Capacity and capability

While residents appeared content living in this centre and satisfied with the service being provided to them, inspectors found the leadership and management of the centre remained poor and was not ensuring a good quality service was being provided. There was an absence of appropriate oversight systems to ensure care and support were delivered to a good standard and in line with the Regulations. For example, there was an absence of an effective system of assessing and planning for residents' needs and an absence of strong safeguarding practices. As a result of the findings from this inspection and previous inspections, the Chief Inspector was not satisfied the provider had the capacity or capability to meet the requirements of the Regulations and made the decision to issue the Provider with a notice of proposal to refuse the registration renewal.

Some improvements were noted since the previous inspection however, it remained there was a lack of an effective system to audit and review the practice and oversight of the care being provided. Inspectors found the centre and staff to be welcoming, and interactions between staff and residents were relaxed and warm. While this was a very positive thing, it was not a stand alone indicator that the provider was offering a good quality service.

Inspectors found that, subsequent to the previous inspection, there continued to be an absence of robust safeguarding mechanisms, and a clear understanding and knowledge on best practice in safeguarding adults with intellectual disabilities. Policies did not inform clear practice, and on reviewing the process that was

followed for an incident notified to the Health Information and Quality Authority (HIQA) in February, inspectors found there was confusion around the national policy for the safeguarding of vulnerable adults, Trust in Care and the management of complaints. The provider's policy on safeguarding did not effectively advise on how to work within these national policies which had resulted in gaps in the provision of a streamline and transparent process in line with national policy, and a failure of the provider to see the systemic issues within the individual incident, and make improvements accordingly.

The provider had failed to demonstrate that they had the capacity and capability internally to bring about improvements in line with best practice and to effectively oversee the operational management of the centre. While some improvements were beginning to emerge, the previous compliance plan had not been fully completed as outlined in the written responses, or within the time lines indicated. Issues and concerns that had been raised at the previous two inspections (January 2017, and February 2018) were still evidenced on this inspection, most notably regarding medication management, governance and management, health care, assessments and plans and risk. Tangible improvements were not evident across all key areas. Inspectors found that there was a reliance on external advisers to assist with the writing of policies, procedures and plans to bring about improvement. For example, the policies were not reflective of the centre's practices. Some of the policies in place did not guide correct procedures in line with national policy such as safeguarding. This was not identified by the provider.

In addition, inspectors found that the reliance on external advisers in place of the local management team, resulted in a disconnect between the written work on the provider’s quality improvement plan, the compliance plan submitted to HIQA and the actual findings on the day of inspection. For example, the quality improvement plan highlighted that specific health care plans were required in a variety of areas such as constipation management, epilepsy and adrenaline insufficiency. On the day of inspection there was no evidence that these health care needs were being adequately planned for and supported, and local management were not clear on the creation of these plans. While it was a positive thing for the provider to seek the support of an external adviser, advise and plans had not been successfully followed and it had resulted in a lack of accountability and responsibility of the management team to address areas of concern. Inspectors were not assured that the person in charge had been given full accountability and responsibility to meet their requirements under the Regulations.

Management systems that were in place were not effective in ensuring good oversight of the centre. Inspectors reviewed minutes of management meetings, that occurred weekly, and found that while there was a forum for discussing work in progress, improvements or actions from these meetings could not be measured. There was an absence of routine audits and review of practice beyond areas identified in previous compliance plans to ensure all aspects of care and support were effectively monitored by the provider.

Overall, inspectors determined that while this was a pleasant living environment for residents with a caring staff team and some improvements were beginning to

emerge, appropriate and timely actions had not been taken to ensure failings identified in January 2017, and in February 2018 were addressed. Significant improvements were required to ensure the provider had the capacity and capability to run and oversee a good quality and safe service in line with the Regulations, and achieve renewal of registration.

Regulation 23: Governance and management

There was an absence of strong governance and management systems to effectively oversee the care and support being delivered in the centre.

Auditing and review systems were not effectively improving practice. The provider's compliance plan had not been adequately addressed as specified, and advise of external adviser was not fully followed in practice.

There was unclear accountability and responsibility of the provider and management team to bring about compliance, and provide evidenced based best practice in the centre.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The written policies and procedures were in need of review and updating to reflect practices in the centre and evidence based best practice.

Judgment: Not compliant

Quality and safety

Staff appeared to have a good relationship with residents and interactions were seen to be warm and friendly. Residents told inspectors that they enjoyed their activities and their daily routines. While this was positive, inspectors found that beyond the day to day social activation there was an absence of forward planning for residents with regards to their social, personal and developmental goals. The system to assess and plan for residents' health, social and personal needs and

wishes was not comprehensive.

Inspectors found there to be an absence of health care planning for identified risks and needs. Inspectors reviewed a number of residents' files, and found there to be no clear guidance on how to support various health issues. Inspectors spoke with some staff and the person in charge, and found that some residents' families supported medical appointments and were very involved in residents' health care. While this support was helpful, inspectors found it resulted in a lack of responsibility on the team to have clear plans and practices in place to ensure all health risks or areas in need of support were adequately addressed. There was an absence of health care plans in relation to specific healthcare needs (such as constipation management, adrenal insufficiency, epilepsy, nutrition) to demonstrate how the staff were supporting residents under their care to achieve the best possible health.

Inspectors found that there was limited access to allied health care professionals and multidisciplinary team members. For example, speech and language therapy, occupational therapy and dietician services. These were not provided by the provider, but access was through referral by residents' general practitioner, or services to be bought in by the provider as outlined in the provider's Statement of Purpose. Inspectors found that residents had not been appropriately referred to allied health care professionals where needs were apparent. For example, speech and language therapy and dietician services. In situations where residents had access, there was a lack of support or advocacy from management to ensure residents were benefiting from this multidisciplinary team input, and advise was recorded and incorporated into support plans.

Safeguarding mechanisms were not robust and inspectors found that the provider did not have a good understanding of safeguarding procedures and best practice. For example, since the last inspection the policy on safeguarding had been reviewed and was in draft format. On reading this policy, inspectors found that it did not clearly guide staff on the procedure to follow in line with national policy, and roles and responsibilities were not clearly set out. On review of a recent incident which warranted an investigation under Trust in Care, inspectors were concerned at how this had been responded to, reported and managed. While an adequate investigation had been carried out by an appointed person, inspectors found that there was a delay in viewing this incident as a safeguarding issue and in reporting it to the Health Services Executive. The provider had not adequately ensured an effective process was in place for management and staff to respond to possible safeguarding concerns. While the investigation identified learning from this incident for example, retraining in the use of physical holds, the provider had failed to see the wider systemic issues that were contributors to the escalation of this incident. The inspector noted that the staff team were provided with training in the safeguarding and protection of vulnerable adults on the day of inspection, which was a positive step taken by the provider to increase the awareness and understanding of promoting the safety of residents. Post inspection, inspectors were provided with a new and updated policy on safeguarding which was much more informative in guiding good practice in line with national policy. The provider had taken swift action in response to the verbal feedback given after the inspection in

addressing the deficits in this policy.

There had been two incidents where a resident had hit out at a peer. On discussion with staff, they felt it wasn't intentional but more so attempt at communicating something. While these two incidents had not resulted in any harm or distress, it was not being viewed as a something with the potential to be a safeguarding issue. It had also not been risk assessed or reviewed effectively to determine how to reduce the likelihood of it happening again, or the underlying cause. There was no access to or referral made to speech and language therapy for the resident, and no clear communication plan in place. Inspectors were concerned, that due to unmet needs, limited assessing and planning and a lack of referrals to multidisciplinary professionals that it was likely that situations could escalate for residents in the future.

Some positive steps had been taken since the previous inspection by the provider, with staff training in the area of safeguarding vulnerable adults being carried out on the day of inspection. There was also now a behaviour support specialist linked in with the service on a consultancy basis, this process had just begun and was an improvement since the last inspection. There was a plan for a number of residents to be reviewed by the behaviour support specialist and clear and effective support plans to be put in place. Following the inspection, the provider had confirmed that training would also be given to staff in the area of positive behaviour support on 03 July and 19 July 2018.

It remained however that further improvements were required with regards to supporting residents with behavioural needs. With the absence of effective behaviour support plans alternative measures and supports were not always considered prior to chemical or restrictive interventions being implemented. While some residents received medicine at times of high anxiety, in the absence of assessments, plans and multidisciplinary team support, it could not be demonstrated that alternative measures and supports were always considered prior to chemical intervention. This was coupled with the absence of clear protocols around the use of PRN (medication taken as the need arises) medicine. Similarly, where residents had restrictions in relation to food, this was not clearly outlined in a rights based way. Evidence of alternative supports were also not recorded.

Inspectors reviewed the risk register, and saw some improvement in the risk document which was a positive finding. Similarly, the risk assessments completed for individual residents were easy to follow, and included all risks in one document. Since the previous inspection, a risk assessment had been completed to determine how safe it was for some residents to be home alone in relation to the risk of fire. It was a positive step that the provider had looked at this through a risk based approach following the last inspection. That being said, risk management overall still required some improvement. Not all risks were being identified, assessed and managed appropriately. There was a disjointed approach to viewing risks, with evidence that staff and residents themselves had different ideas on control measures that may be needed.

Accidents, incidents or adverse events were being recorded, and placed in residents'

files. Inspectors were told incidents were reviewed weekly. However, a stronger system of reviewing and learning from incidents was required. The person in charge had just begun to amalgamate all incidents over the past number of years to look at it from the perspective of learning. Some patterns were beginning to emerge and learning could be garnered from same.

The practices around medication management had been raised as an issue on the past two inspections and inspectors found that practices were still not fully clear.

Secure facilities for the storage of residents' medicines were in place with separate facilities to store out of date or unused medicines. However, guidance in relation to the administration of PRN medicines (medicines only taken as the need arises) was not consistent, and did not guide staff appropriately in administering medicine safely as prescribed. Medication records showed two medicines prescribed as PRN for one resident with contra-indicating sedative side effects. Inspectors were informed that one of these medicines was no longer in use, or in stock in the centre and therefore could not be administered in error. That being said, the systems in place for ensuring records were up to date required review. Following the inspection, inspectors sought assurances from management that this would be addressed, so that errors could not occur.

Overall, inspectors determined that while residents were provided with a comfortable and homely environment and a warm staff team, significant improvements were required in order for the provider to ensure a consistently safe, person-centred service was being delivered to all residents.

Regulation 26: Risk management procedures

There was an absence of an effective risk based approach in the delivery of care and support.

Risk management systems required improvement to effectively identify, assess and manage all clinical and personal risks.

Review of risk and adverse events was also in need of improvement.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had put fire doors in place since the last inspection. Fire drills had been carried out and risk assessments completed to determine levels of risk regarding

residents being home alone in the event of an emergency.

There were fire safety systems in place in the centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Failings from the last inspection had not been properly addressed. Medication management practices and the oversight of this were in need of address to ensure clear and effective recording and prescription records were maintained.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The system for assessing residents' needs was not comprehensive, and did not include input from a multidisciplinary team.

The provider had failed to put plans in place to address residents' health, social and personal needs and risks.

The review of information in residents' basic assessments was not ensuring supports were effective.

Judgment: Not compliant

Regulation 6: Health care

There was limited access to allied health care professionals and multidisciplinary team members.

Residents had not been appropriately referred to allied health care professionals where needs were apparent.

In situations where residents had access to multidisciplinary support, there was a lack of support or advocacy from management to ensure residents were benefiting from this multidisciplinary team input.

Records were not well maintained.

Judgment: Not compliant

Regulation 7: Positive behavioural support

While some improvement was noted with the addition of support from a behaviour support specialist, there were still failings in relation to this Regulation:

- alternative measures and supports were not considered prior to chemical interventions.
- staff had not been provided with the skills and knowledge to support residents in a positive and proactive way regarding their behaviour.

Judgment: Not compliant

Regulation 8: Protection

The provider did not demonstrate through their policies, procedures, knowledge and management of incidents that a strong system was in place to safeguard residents from potential harm.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for National Association of Housing for Visually Impaired OSV-0001938

Inspection ID: MON-0024209

Date of inspection: 18/06/2018

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:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- NAHVI has commissioned Positive Futures to assign an Operations Manager for the centre who will oversee and ensure the reconfiguration of the service to meet the regulations set out and ensure compliance with Regulation 23 and others.
- Positive Futures Executive Director who will assume the role of Registered Provider Representative is scheduled to commence direct engagement on site in the centre from 7 August 2018 with the residents, staff, relatives and the HSE (CHO DNCC).
- NAHVI & Positive Futures have commenced engagement and agreed training, oversight, direct management of the residential centre and person centred planning processes as priorities for the centre in line with compliance issues identified by the inspector
- Positive Futures has identified an Operations Manager for NAHVI whom the PIC will report directly to.
- NAHVI and Positive Futures will have a Memorandum of Understanding in place to support the transition phase effective from 7 August 2018 to 30 January 2019.
- This Memorandum of Understanding will provide for Positive Futures to manage and govern all aspects of service delivery and HR management in the centre whilst the timeframe set out within the Memorandum tolerates the extension of same from January 2019 if agreed by both parties. The Memorandum of Understanding will be completed by 3 August 2018.
- Since the inspection on 18 June 2018, the Registered Provider has assigned two Social Care Workers as Deputy Persons in Charge/Shift Leaders. The Registered Provider has aligned the responsibilities of each member of the management team to ensure appropriate oversight and management of the centre in line with Regulation 23 requirements.
- The incoming Provider Representative will meet monthly with the incoming Operations Manager, Person in Charge and the Person(s) Participating In Management to ensure the roles and responsibilities identified in the revised management structure and in job profiles are met and that each person is

proficient and skilled to deliver the service required.

- A monthly audit schedule will be developed which will ensure that the practice associated with all 34 regulations will be adhered to over the next six months effective from 1 September 2018.
- Audit tools will be developed to make certain that the policies and procedures which govern practices are relevant and guide best practice in the centre. The audit tools will be used to ensure that the practice of the designated centre results in a positive experience for all residents at all times.
- Starting 1 September 2018, monthly audits will be completed for each of the regulations which have were identified as non-compliant in the June 2018 inspection.
- NAHVI commit to submitting a monthly report to HIQA from September to December 2018 inclusive identifying the progress achieved as an assertion mechanism to HIQA of the commitment of the provider to achieve full compliance with the regulations and provide a person centred, safe and effective service.
- A compliance plan will be generated from each audit referred to above with a timeframe for completion of all actions identified. Each finding will be risk rated in line with the service risk management policy to ensure that actions are prioritised and the appropriate timeframe and person responsible are assigned. The timeframe identified will also ensure that the appropriate time is given to ensure the "bedding in" of the actions and new ways of working.
- Training will be provided to individuals who are completing the audit to ensure that they are competent in the area of practice and in conducting audits.
- The Provider Representative will also nominate a member of the team to complete an unannounced visit on a monthly basis at various times to ensure that the day to day practice is conducted in a manner which promotes the dignity of residents. This will be recorded, and actions assigned, where applicable, within agreed timeframes and copies made available in the centre. This will be undertaken until February 2019.Learning from the audits and unannounced visits will be disseminated to staff through monthly team meetings. This will also inform a training schedule which will be delivered to staff over a six-month period. Training will be provided in line with the risk associated with the actions identified. If required, deficits in individual practice will be addressed through staff supervision and management plan as per policy on staff supports.

The above compliance plan is expected to be completed in full by 28 February 2019.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A review of existing Policies, Procedures and Guidelines has commenced, and priority has been assigned to Schedule 5 policies within the centre. The review will be enhanced by the incoming Operations Manager of the designated centre to ensure that they are relevant and guide the day to day practice and functioning of the designated centre. The review will ensure that polices incorporate obligatory national policy and consequently required amendments will be made and approved by the Provider Representative.

Priority is, and will continue to be, given to the following policies:

- Safeguarding: review completed and revised policy in place
- Risk Management;
- Assessment and Personal Planning including access to Allied Health Professionals
- Safe Medication Management
- Positive Behaviour Support

All Schedule 5 Policies will be reviewed to include engagement with all frontline staff and meaningful use of the policies in day to day operation of the centre by 30 November 2018 and these will be reviewed 3 yearly, or in response to the Chief Inspectors requirements thereafter.

All remaining Policies and Procedures that have not been reviewed within 3 years will be reviewed by 28 February 2019 and at a minimum of 3 yearly thereafter.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

- The Registered Provider, in conjunction with the management team, has revised and updated the risk management policy for the designated centre to include components identified in regulation 26 (1) (a) (b) (c) (d) (e) and in line with national policy.
- Training will be delivered to staff in the policy, with learning identified from previous deficits in practice, incorporated into this training.
- The risk register of the designated centre will be reviewed to ensure that it includes all clinical, operational and environmental risks and will be maintained by the Person in Charge and reviewed minimum quarterly or more often as required.
- In line with the review of policies and procedures and the assessment of each individual, an assessment will be completed of any risks associated with the individualised supports each resident requires. Control measures will be identified.
- All adverse events will be recorded with 24 hours of the incident and reviewed with management within 3 days of them occurring. The review will include identifying if the adverse event resulted from a known risk to a resident. If so, the existing control measures will be evaluated to ascertain if they were effective and/or implemented in practice. If they were not implemented, this will be addressed with the individuals involved and necessary action will be taken. Additional control measures will be identified, in consultation with the resident, if necessary.
- All adverse events will be reviewed at monthly meetings to share learning and a learning template will be developed to document same and share with all staff

The above compliance plan is expected to be completed in full by 30 December 2018.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- The medication management policy has been reviewed to ensure that it is

informed by evidence-based practice and guides the practice of the designated centre. Staff will receive revision training in safe administration of medication which will include three competency-based assessments. Revision training to be completed by 30 September 2018.

- The Prescriber plans to review the medications prescribed to each resident to ensure that they are necessary. No medication will be administered to a resident, in the absence of a valid prescription. Each medication will be signed for by staff on receipt, administration or disposal. Reviews by Prescriber to be completed by 1 September 2018
- A reconciliation of medication will occur on a weekly basis and will be overseen by the Person In Charge.
- A review of the storage arrangements has been completed and adjustments made to ensure medication is stored in line with regulations and policy.
- A monthly audit of all steps in the medication management cycle will be carried out to ensure that policy is adhered to, effective from 7 August 2018
- Any diversion from policy will be addressed with the specific staff member through a performance management plan. Learning from medication errors will be discussed at monthly staff meetings and recorded on learning notices to share with all.
- The pharmacy has also agreed to conduct 6 monthly audits of the medication management practices of the centre.

The above compliance plan is expected to be completed in full by 30 September 2018.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

- Following the review and development of the policy on assessment and person centred planning, each resident will receive a comprehensive assessment of their health and social care needs with the appropriate staff. This will be completed by 30 December 2018.
- If a need is identified, a plan will be developed which identifies the personal supports that each individual may require to ensure their needs are met.
- If additional assessment is required, referrals will be made to the appropriate allied health professional through their primary care team.
- Personal plans will be reviewed by the Named (Key) Worker and the resident on a monthly basis. These reviews will include the supports the residents received in the previous month to assess the effectiveness of the supports. Amendments will be made to the plans where appropriate or requested by the individual to ensure that the supports in place are effective.
- Any changes will be communicated to team members at each staff handover and staff will sign off to validate that they are aware of the changes. The needs of the residents will also be reviewed at team meetings on a monthly basis. Assessments and personal plans will be audited on a monthly basis as part of audit schedules. Personal plans will also be reviewed with the appropriate Named Workers at formal supervision. Any deficits in practice will be identified and a performance plan developed which will include the provision of relevant training or mentoring for the staff member

Completion of initial revised person centred planning model for all residents by 30 December 2018.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

- In line with the review of policies and procedures and the assessment of each person supported, the personal plan developed will ensure that the healthcare needs of each individual are identified and the specific supports they required are clearly documented. This will include the supports required on a day to day basis, referrals, if any, required and all appointments with the relevant health care professionals. Completion by 30 October 2018.
- The team, in consultation with the resident concerned, will document all supports provided to that person and the effectiveness of the supports. If supports are deemed to be ineffective this will be brought to the attention of the relevant health care professional. The health care provided to residents will be reviewed by the Person In Charge on a weekly basis. Any deficits in practice will be addressed with the staff involved through a performance management plan which will include bespoke training. Completion by 28 February 2019.
- An emergency plan will also be developed for any specific risks associated with the specific health care needs of residents which identify the indicators of ill health and the specific actions to be taken if the indicators are present. Completion by 30 September 2018.
- A communication passport informed by best practice will be provided for all residents by 30 March 2019.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- In line with the review of policies and procedures and the assessment of each individual's needs, a comprehensive review of the positive behaviour support that each resident requires will be completed. The support required will be identified in the personal plan of the resident and communicated to staff through bespoke training which will be delivered by the appropriate professional. The team, in consultation with the resident concerned, will document all supports provided to the resident and the effectiveness of these supports. This support will be reviewed on a weekly basis by the Person In Charge.
- All restrictive practices in the centre will be reviewed, in consultation with the resident and the relevant allied health professional, to ensure that they are the least restrictive practice and are used for the safety and wellbeing of each resident. Less restrictive alternatives will be sought and implemented if deemed suitable. Restrictive practices which have been implemented by staff will be documented and reviewed with staff at team meetings and at formal supervision. Any deficits in practice will be identified and a performance management plan developed which will include the provision of relevant training. Restrictive practice will be reviewed on a weekly basis by the Person In Charge to ensure that they are applied in line with the personal plan and are necessary. Any diversion from the personal plan will be addressed with the staff members involved.

To be completed by 31 November 2018.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- The policy for the protection of vulnerable adults has been reviewed to ensure that it is in line with national policy. Training in the policy will be delivered to staff, with learning identified from previous deficits in practice incorporated into the training by 30 August 2018.
- A clear process is in place which identifies an individual on a 24/7 basis who is available to respond to any queries staff may have following an adverse event to ensure all allegations or suspicions of abuse are reported, the individuals concerned are safe and the policies and procedures are adhered to.
- Residents will also be consulted with and informed of their rights in respect of safeguarding. This will be completed on an individual basis by identified staff / Named Workers and any concerns identified will immediately be reported to the Designated Officer and the appropriate action taken.

To be completed by 30 August 2018.

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 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.	Substantially Compliant	Yellow	7 August 2018 (Revised structure will be submitted to Inspector)
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30 January 2019
Regulation 23(1)(d)	The registered provider shall	Substantially Compliant	Yellow	28 February 2019

	ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30 December 2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30 September 2018
Regulation 04(3)	The registered provider shall review the policies	Not Compliant	Orange	Schedule 5 Policies by 30 November 2018

	and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			(all others by 28 February 2019)
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, 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.	Substantially Compliant	Yellow	30 December 2018
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30 December 2018
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the	Not Compliant	Orange	30 September 2018

	designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 05(6)(a)	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 be multidisciplinary.	Substantially Compliant	Yellow	30 December 2018
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30 December 2018
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30 March 2019
Regulation 06(2)(d)	The person in charge shall	Substantially Compliant	Yellow	30 March 2019

	ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30 October 2018
Regulation 7(5)(a)	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.	Substantially Compliant	Yellow	30 November 2018
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are	Substantially Compliant	Yellow	30 November 2018

	considered before a restrictive procedure is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	30 August 2018