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

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Clew Bay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>St Michael's House</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Dublin 11</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>28 November 2018</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0002334</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0025096</td>
</tr>
</tbody>
</table>
About the designated centre

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

Clew Bay is a community home for eight adults with an intellectual disability. Residents are supported when required with budgeting, cooking and other activities of daily living. The centre consists of two premises within walking distance of each other. One premises is a two-storey, end of terrace house with five bedrooms, three bathrooms, a kitchen, dining and living spaces. The other premises is a three bedroome d terraced house situated on a cul de sac. Upstairs it has three bedrooms, one of which is ensuite, and a bathroom. It has two sitting rooms, one of which is also the staff sleepover room, a kitchen/dining area and a utility room downstairs. Both premises are connected by adjoining back gardens and situated close to a local village in Co. Dublin. Facilities close by include shops, pubs, churches, garda station, credit union, banks, parks, a swimming pool and a library. The local shopping centre is a 10 minute walk and the area is well served by public transport. Care and support in the centre is provided by a person in charge and social care workers. Residents can access nursing support via the nurse manager on call service if required.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 8 |
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>28 November 2018</td>
<td>09:00hrs to 16:00hrs</td>
<td>Marie Byrne</td>
<td>Lead</td>
</tr>
<tr>
<td>28 November 2018</td>
<td>09:00hrs to 16:00hrs</td>
<td>Michelle McDonnell</td>
<td>Support</td>
</tr>
</tbody>
</table>
Views of people who use the service

The inspectors had the opportunity to meet five of the eight residents who lived in the centre on the day of the inspection. Residents who spoke with the inspector stated that they liked their home and were happy. They described opportunities for meaningful activities and told the inspector that they had things to look forward to. Each of the residents described their involvement in the day-to-day running of their home.

Residents were observed by inspectors throughout the day to be engaging in activities of their choosing. Staff were observed to be kind, caring and respectful with residents. Each of the residents who spoke with the inspectors were complimentary towards the staff and the support they received from them. One resident showed the inspectors their all about me book and described their likes, dislikes and important people in their life.

From speaking with residents it was evident that there was positive risk taking in the centre and that they were free to choose how and where they spent their time. It was evident that residents' potential and independence were being encouraged. A number of residents described how they were actively participating in their local community.

In line with the findings of previous inspections concerns remained regarding the compatibility of some residents in the centre. The provider had recognised this and there were safeguarding plans and risk assessments with control measures in place to keep residents safe.

Capacity and capability

Overall, the inspectors found that the registered provider and person in charge were not adequately monitoring the quality and safety of the service. This was the third inspection in the centre in 2018. As a result of concerns during the previous two inspections the provider was required by the Office of the Chief Inspector (OCI) to attend meetings to provide assurances in relation to the significant levels of non-compliance with the regulations on these inspections. The provider was required to attend a meeting following each of the three inspections that occurred in 2018. Following this inspection, November 2018, the provider was requested by the OCI to attend a warning meeting where a warning letter was issued in relation to the sustained non compliance with the regulations and their failure to demonstrate reasonable improvement. They have been requested to submit an improvement plan to the OCI and following this to provide monthly updates until the centre has come into compliance to the satisfaction of the OCI.

The inspectors acknowledge that the management structure in the centre had
recently been reviewed and strengthened. A new director of services and person in charge were now in place. The service manager who has been identified as a person participating in the management of the designated centre (PPIM) was in post three months. The person in charge had commenced two weeks prior to the inspection and the inspectors did not get an opportunity to meet them as they were not on duty on the day of the inspection. During the inspection plans to increase the monitoring and oversight of the centre were outlined to the inspectors. However, the systems in place at the time of the inspection were not proving effective as they were not ensuring full oversight and monitoring of the service. In addition, the provider had not followed through on multiple actions within the timeframe they had identified for themselves.

The staff team reported to the person in charge who in turn reported to the service manager. Staff meetings were being held regularly and agenda items were found to be resident focused. Improvements were noted since the last inspection such as bringing in key personnel from within the organisation to talk to staff about areas of care and support. A social worker had attended the latest staff meeting in relation to safeguarding procedures and how staff should escalate concerns. However, on reviewing the minutes of these meetings the inspectors found a number of items discussed which did not respect residents' rights to privacy or choice.

Throughout the inspection residents appeared happy and relaxed in their home and with the support offered by staff. Staff members were found to be knowledgeable in relation to residents' care and support needs and motivated to support residents to maintain and where necessary develop skills to become more independent. However, the inspectors reviewed rosters and found that in line with residents' changing needs there were not sufficient numbers of staff to ensure each resident's needs were met. The provider had recognised this and was in the process of reviewing whole time equivalent numbers and had submitted a business case for funding prior to this inspection. In addition, the provider had also recognised the need to put additional staffing support in place in line with one resident's recent needs. They were covering these additional support hours with regular agency staff and a new staff was due to start in the centre the week after the post inspection. The inspectors found that planned and actual staff rosters were not properly maintained in the centre.

There were management systems in place such as the annual review and six monthly review of quality and safety. The inspectors reviewed the latest six monthly review which had been completed four weeks prior to the inspection. This review did not identify all areas for improvement in the action plan. In addition, the actions which were outlined in the action plan did not identify who was responsible for completing them, or by when they should be completed. The findings of this review did not identify areas for improvement in line with the findings of this inspection. The annual review for 2018 was not yet due and was in development at the time of the inspection. Audits were being completed regularly including medication audits, residents' finances, and health and safety. There was evidence that the completion of actions following some of these reviews which were bringing about positive changes in relation to residents' care and support.
A new template was developed for support meetings between the PPIM and person in charge. On reviewing this template it was detailed and there were sections for review of the quality and safety of the service for residents. However, the inspectors reviewed the minutes of one of these meetings and found that all aspects of care and support were not discussed and all sections of the template were not fully completed.

There was a Quality Enhancement Plan (QEP) in place in the centre. In line with the findings of the last inspection this document was limited to follow up actions from inspections. It did not address other important aspects of care and support such as residents' rights, dignity and consultation, communication, use of resources or maintenance.

The inspectors found that an allegation of abuse had not been notified the Office of the Chief Inspector (OCI) in line with the requirement of the regulations. There was evidence that the person in charge had escalated the incident within the organisation however, at this point it was deemed, incorrectly, as not being a notifiable event.

**Regulation 15: Staffing**

Each staff member who spoke with the inspectors was found to be knowledgeable in relation to residents' care and support needs. At the time of the inspection the staffing levels and skill mix were not sufficient to meet residents' assessed needs. The provider had recognised this and whole time equivalent numbers and the skill mix were being reviewed by the provider in line with residents' changing needs.

Judgment: Not compliant

**Regulation 23: Governance and management**

The inspectors acknowledge that a number of changes to the management structure in the centre had occurred since the last inspection. However, suitable arrangements were not in place at the time of inspection to effectively monitor care and support for residents. The six monthly review of quality and safety was not identifying areas of improvement in line with the findings of this inspection. Management systems had been further strengthened since the last inspection but were in their infancy and yet to fully impact residents' lived experiences.

Judgment: Not compliant
**Regulation 3: Statement of purpose**

The statement of purpose contained the information required by Schedule 1 of the regulations and had been reviewed in line within the time-frames identified in the regulations.

Judgment: Compliant

**Regulation 31: Notification of incidents**

An allegation of abuse had not been notified to the OCI in line with the requirement of the regulations.

Judgment: Not compliant

**Quality and safety**

Overall, the inspectors found that staff were striving to ensure that residents lived in a caring environment where they had opportunities to make their own choices and decisions. However, the provider was not ensuring that the quality of the service provided for residents was safe and of a good quality. Significant improvement was required in relation to residents' rights, the review of the effectiveness of personal plans, risk management, safeguarding and the premises.

Both premises were found to be warm, clean, comfortable, homely and decorated in line with residents' wishes. However, significant improvements were required in relation to the maintenance and upkeep of the premises. These areas for improvement included: damage to the kitchen and counter top in one house which had resulted in the fridge being placed in the dining room. There was damage and mould to areas such as living room and bathroom ceilings. There were a number of areas where there had been maintenance works but they had not been fully completed. Some of the areas that required maintenance had been recognised in the centre's QEP and a plan was in place to complete required works. However, a number of the required improvements had not been recognised or reported.

In response to residents' changing needs, staffing arrangements had been reviewed and a sleepover staff introduced in one house. However, the design and layout of the premises required review in line with these changes. The sleepover room for staff was also the residents' living room.

Through discussions with residents and staff and on reviewing documentation it was evident that residents were supported to make decisions about their lives and that
they were listened to with care and respect by staff. Their views were taken into account and residents were free to choose how they spend their day. They were enabled to take reasonable risks within their day-to-day lives. However, through review of personal plans and other documentation in the centre inspectors found that one resident required support to ensure they were making informed choices and decisions. The documentation outlined that the resident was engaging in activities which may make them vulnerable in as much as it could lead to the resident’s legal rights being affected. This was also leading to the residents’ privacy and dignity not being respected in relation to the sharing of their personal information. This residents' vulnerability to abuse was not being recognised or appropriately assessed particularly in relation to accessing his local community. The resident required support to develop their knowledge and skills for self-care and protection. This was discussed with the provider at feedback following the inspection and inspectors were given assurances that this would be reviewed.

The inspectors found that the organisations' policy on protection of adults from abuse and neglect, contained information and guidance that was contradictory to the national safeguarding policy. Furthermore, the procedures contained within the policy were found to be inconsistent, and did not effectively guide staff practice. The systems in place were not ensuring incidents were screened appropriately in order to protect residents. In addition, in line with the findings of the previous inspection, the inspectors found documentation in the centre such as safeguarding plans and risk assessments which indicated that there were compatibility issues between residents in the centre. The provider was aware of this and had strengthened systems in the centre to keep residents safe such as incident review, review of safeguarding plans and risk assessments. However, the organisations' policy and procedures were not ensuring all incidents were appropriately screened.

Overall, residents’ personal plans were found to be person-centred. However, there was conflicting information in different sections of a number of residents' personal plans reviewed by the inspectors. This was resulting in lack of guidance for staff in relation to supporting residents with their care and support needs. In addition, there were a number of personal plans which required review as they were not guiding staff to support residents not to take unnecessary risks in line with their changing needs. There was evidence of regular review of residents' personal plans. However, these reviews were not resulting in changes being made to the documentation in line with residents' changing needs and were not picking up on the conflicting information contained in the personal plans.

Residents who required them had positive behaviour support plans in place. The plans reviewed by the inspectors were clear and guided staff to support residents to manage their behaviour. Staff were knowledgeable in relation to residents' positive behaviour support plans. However, on reviewing positive behaviour support plans and through discussions with staff, the inspectors found that staff required support to up skill in relation to appropriately supporting residents to manage their behaviour. This particularly related to times when residents' behaviour support needs increased. Restrictive practices were reviewed regularly to ensure that the least restrictive practice was being used for the least amount of time.
The inspectors found that residents were not being protected by appropriate risk management systems. There were policies and procedure to guide staff practices and expertise had been sourced from within the organisation to review systems in the centre. However, on reviewing risk assessments the inspectors found that whilst some were detailed and clearly guided staff practice, others were not detailed and did not contain adequate control measures to keep residents safe. For some identified there were effective control measures, persons responsible and actions, and evidence that these were reducing the risks. However not all risks were identified, and additional control measures in some risk assessments were not reviewed to ensure they were effective. Some residents did not have risk assessments developed in line with their changing needs.

**Regulation 17: Premises**

Both houses were clean and homely. Residents described their involvement in keeping their home clean and tidy. Improvement was required to the maintenance and upkeep of both houses and the design and layout of one premises was not meeting residents' needs as outlined in the body of the report.

Judgment: Not compliant

**Regulation 26: Risk management procedures**

The inspectors found that whilst there were policies and procedure in place for risk management, these policies and procedures were not being fully implemented. There was evidence that there were risk assessments in place with effective control measures for some risks which were proving effective. However, not all risks were identified or risk assessed. In addition, additional control measures in some risk assessments were not reviewed to ensure they were effective.

Judgment: Not compliant

**Regulation 5: Individual assessment and personal plan**

Residents' personal plans were found to be person-centred. However, there was conflicting information found in residents' personal plans which could negatively impact residents. There was evidence of regular review of residents' personal plans. However, these reviews were not identifying required changes to documentation in line with residents' changing needs.
Judgment: Not compliant

**Regulation 7: Positive behavioural support**

Residents who required them had positive behaviour support plans in place which clearly guided staff to support them. Staff were knowledgeable in relation to residents positive behaviour support plans and there was evidence that restrictive practices were reviewed regularly to ensure that the least restrictive practice was being used for the least amount of time. However, the inspectors found that staff required support to up skill in relation to appropriately supporting residents to manage their behaviour, particularly when their behaviour support needs increased.

Judgment: Substantially compliant

**Regulation 8: Protection**

In line with the findings of previous inspections there were compatibility issues between a number of residents in the centre. The provider had recognised this and safeguarding plans and risk assessment were in place to keep residents safe. However, not all residents' safeguarding needs were being recognised or supported as outlined in the body of the report. The inspectors found that the organisations' policy on protection of adults from abuse and neglect required review as it was not effective in guiding staff practice.

Judgment: Not compliant

**Regulation 9: Residents' rights**

Overall, the inspectors found that there was a sensible balance between the choices residents make and reasonable risks they want to take, and their safety. However, one resident required support to ensure they were making informed choices and decisions. In addition, this resident's privacy was not being respected in relation to the sharing of their personal information.

Judgment: Not compliant
## Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Notification of incidents</td>
<td>Not 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>Not compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Not compliant</td>
</tr>
</tbody>
</table>
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>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Staffing</td>
<td>Not Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 15: Staffing:

In response to the area of non-compliance found under Regulation 15 (1) and Regulation 15 (4)

- The provider has submitted an improvement plan for the centre and will provide monthly updates to the OCI in relation to this regulation

- Roster review completed on the 30/11/18 by the Person in Charge, Service Manager, and HR manager to ensure the provision of consistent staffing with suitably qualified staff for the centre.

- The Person in Charge will ensure that the monthly roster reflects the needs of the residents.

- All necessary HR and employment control paperwork will be completed for 4 staff vacancies.

- Planned and actual rosters for Feb, March, April and May will be reviewed by the PIC, Service Manager and Admin Manager to ensure that the numbers and skill mix of staff are appropriate to meet the needs of the service users.

<table>
<thead>
<tr>
<th>Regulation 23: Governance and management</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

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

In response to the area of non-compliance found under Regulation 23(1)(c)

- The provider has submitted an improvement plan for the centre and will provide monthly updates to the OCI in relation to this regulation

- Fortnightly governance and management meetings with PIC, Service Manager, Director
of Service and Director of Quality Improvement and Safety Development will be established. Minutes will be kept identifying what needs to be done, by whom and by when.

- Monthly data sheets will be introduced in the centre and will include information and analysis of accidents/incidents/behaviours that challenge/peer to peer interactions/complaints. These will be discussed and necessary actions agreed by the PIC and Service Manager at their monthly meetings and at the fortnightly governance meetings.

- The PIC will have additional management time on the roster to support improvement in Governance and Management

- A clear management structure will be developed with lines of accountability, authority and specific roles and responsibilities.

- A review of actions from the 6 monthly reports and most recent annual review of the service will be undertaken to identify and prioritise actions for implementation.

- Staff resources for this designated centre will be discussed and prioritised with the Executive Management Team and a report for the Board of Directors will be prepared outlining the resources required and the actions agreed to support this designated centre.

In response to the area of non-compliance found under Regulation 23(2)(a)

- A schedule of internal audits will be developed for 2019. These will include a Health and Safety Audit, Risk assessment and risk register audit, Medication audit, Assessment of Need and support plan audit, Fire safety audit, audit of service users monies and a staff training audit. A QEP with actions to be completed will be updated following the audits. This will be reviewed as part of the PIC/Service Manager monthly meetings

- An additional 6 monthly audit focusing on Governance and Management will be carried out in the centre to ensure the systems introduced are improving the governance arrangements.

In response to the area of non-compliance found under Regulation 23(3)(a)

- Supervision and support meetings for the Staff Team, PIC and Service Manager will be scheduled and matters discussed will be documented. Staff meetings and cluster meetings will continue and will form part of support and supervision arrangements for the staff in the designated centre.

- At the supervision meetings with Staff, PIC and Service Manager a standing item on the agenda will be to discuss any concerns staff members have about the designated centre or the care provided to service users. These will be included in the notes of the meeting and will be discussed at the fortnightly governance and management meetings.

| Regulation 31: Notification of incidents | Not Compliant |
Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In response to the area of non-compliance found under Regulation 31(1)(f)

- The provider has submitted an improvement plan for the centre and will provide monthly updates to the OCI in relation to this regulation
- A retrospective NF06 was sent in on the 20/12/18
- Information session on reporting and management of Safeguarding concerns to social work department and the Authority was held with staff team and the PIC.
- PIC and Service Manager will report all incidents of safeguarding to the Principle Social Worker for screening as safeguarding concerns. These concerns are notified to the Authority as NF06
- Fortnightly governance and management meetings with PIC, Service Manager, Director of Service and Director of Quality Improvement and Safety Development will be established. A standing item on the agenda is a review of peer to peer behaviours for previous period and the NF 06 submitted.
- PIC will seek feedback from the staff team (at staff meetings) on implementation of safeguarding plans and will review and update as necessary

<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>In response to the area of non-compliance found under Regulation 17(1)(a)</td>
<td></td>
</tr>
<tr>
<td>- Review and update of all residents’ assessment of need and supports plans will be completed by the 31/1/19.</td>
<td></td>
</tr>
<tr>
<td>- Director of Service will commission a review of the designated centre to consider if the centre is effective in meeting the support needs of all residents by the 31/1/19</td>
<td></td>
</tr>
<tr>
<td>- The Director of Service will review the review of the service commissioned in January and will agree implementation plans</td>
<td></td>
</tr>
</tbody>
</table>

In response to the area of non-compliance found under Regulation 17(1)(b)

- Head of Technical Services completed a walk through with PIC on the 12/12/18. All areas for improvement were identified.
- The Director of Adult Services is meeting with Head of Technical Services on the 3/1/19 to review outstanding work for the centre and schedule dates and times for completion of work, subject to minor capital being available.

<table>
<thead>
<tr>
<th>Regulation 26: Risk management procedures</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>
Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

In response to the area of non-compliance found under Regulation 26 (2)

- The provider has submitted an improvement plan for the centre and will provide monthly updates to the OCI in relation to this regulation

- A review of the risk register and risk assessments in the centre will be undertaken to ensure they are up to date and reflect the control measures that are in place.

- Risk assessments and the risk register will be updated based on the review above

- Refresher Training for PIC/ PPIM/ Other staff in the centre on risk assessments and risk management will be scheduled

- The Registered Provider will review the Risk Management Policy to ensure it guides practice in assessing risk, recording risks and escalating risks where appropriate.

- A review of the risk register following the implementation of additional control measures outlined in the strategies in the regulations above will be conducted to ensure the risks in the centre have reduced.

---

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

In response to the area of non-compliance found under Regulation 05(6)(c) and Regulation 05(6)(d)

- The provider has submitted an improvement plan for the centre and will provide monthly updates to the OCI in relation to this regulation

- One assessment of need reviewed and updated on the 5/12/18.

- Review and update of other residents’ assessment of need and supports plans to be completed by the 31/1/19.

- Director of Service will commission a review of the designated centre to consider if the centre is effective in meeting the support needs of all residents by the 31/1/19.

- All About Me’s for all residents will be updated/ developed to reflect what is important to each individual

- A schedule of annual multi-disciplinary outcome review meetings will be developed by the 30/3/19.

- The Director of Service will review the review of the Service commissioned in January
2019 and agree implementation plans.

<table>
<thead>
<tr>
<th>Regulation 7: Positive behavioural support</th>
<th>Substantially Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In response to the area of non-compliance found under Regulation 07(1)

- An Individual co-ordination meeting held on the 11/12/18 in attendance Consultant Psychiatrist, PIC, Service Manager, Senior Clinical Psychologist and Director of Service. Positive behavior support plan was reviewed and amended by Senior Clinical Psychologist following this meeting.

- The Senior Clinical Psychologist and the Consultant Psychiatrist will attend a staff meeting in the centre to support staff in managing residents’ behaviours, particularly when their behaviour support needs are increasing.

<table>
<thead>
<tr>
<th>Regulation 8: Protection</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 8: Protection:
In response to the area of non-compliance found under Regulation 08(1)

- The provider has submitted an improvement plan for the centre and will provide monthly updates to the OCI in relation to this regulation

- Community Support plan is being developed in consultation with the resident, PIC, Key worker and Senior Clinical Psychologist regarding supporting the residents rights when they are in their community and the sharing of their personal information

In response to the area of non-compliance found under Regulation 08(2)

- Safeguarding Plans for each service user have been developed in the designated centre

- Information session on reporting and management of safeguarding concerns to social work department and The Authority held with staff team and PIC.

- PIC and Service Manager will report all incidents of safeguarding to the Principle Social Worker for screening as safeguarding concerns. These concerns are notified to the Authority as NF06

- Fortnightly governance and management meetings with PIC, Service Manager, Director of Service and Director of Quality Improvement and Safety Development will be established. A standing item on the agenda is a review of peer to peer behaviours for previous period and the NF 06 submitted.

- PIC will seek feedback from the staff team (at staff meetings) on implementation of safeguarding plans and will review and update as necessary
• A DISMAT will be completed for one person and submitted to the HSE for additional resources to support one person.

• Safeguarding committee has been established and policy review will be included in the TOR

• A full review of safeguarding support and their implementation will be held. This will include a review of safeguarding concerns for Nov/Dec/Jan, the implementation of the safeguarding support plans for individuals and the notifications submitted to HIQA will be held and any outstanding safeguarding concerns will be identified.

• Research and Consultation with key stakeholders to be completed

• Draft 1 of reviewed policy reviewed by Social work team/ Safeguarding Panel/ Executive Management Team.

• Draft 2 of updated Safeguarding Policy prepared based on feedback on draft 1

• Consultation on draft 2 to be completed

• Policy Finalised and Implementation plan developed

• Information and training for staff team in designated centre on the updated policy at staff meeting

• Review of implementation of updated Safeguarding Policy in designated centre.

<table>
<thead>
<tr>
<th>Regulation 9: Residents' rights</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 9: Residents' rights: In response to the area of non-compliance found under Regulation 09(3)</td>
<td></td>
</tr>
</tbody>
</table>

• Community Support plan is being developed in consultation with the resident, PIC, Key worker and Senior Clinical Psychologist regarding supporting the residents rights when in they are in their community and the sharing of their personal information

• The PIC will contact Advocacy Ireland and request and advocate for one Resident.

• PIC to invite a member of Advocacy Ireland to a Residents meeting to provide information on their role.
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 15(1)</td>
<td>The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Regulation 15(4)</td>
<td>The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>30/06/2019</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>30/03/2019</td>
</tr>
<tr>
<td>Regulation 17(1)(b)</td>
<td>The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>31/08/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance Status</td>
<td>Color</td>
<td>Date</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
<td>-------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>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>30/03/2019</td>
</tr>
<tr>
<td>23(2)(a)</td>
<td>The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/03/2019</td>
</tr>
<tr>
<td>23(3)(a)</td>
<td>The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>30/03/2019</td>
</tr>
<tr>
<td>26(2)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Regulation</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>Not Compliant</td>
<td>Orange</td>
<td>20/12/2018</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Regulation</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>Not Compliant</td>
<td>Orange</td>
<td>30/03/2019</td>
</tr>
<tr>
<td>Regulation</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 take into account changes in circumstances and new developments.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/03/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>18/02/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>The registered provider</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Regulation 08(2)</td>
<td>shall protect residents from all forms of abuse.</td>
<td>Compliant</td>
<td>Orange</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------</td>
<td>-----------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>Regulation 08(3)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Regulation 09(3)</td>
<td>The registered provider shall ensure that each resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>18/02/2019</td>
</tr>
</tbody>
</table>