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:	No 2 Seaholly
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	24 April 2018
Centre ID:	OSV-0004572
Fieldwork ID:	MON-0021185

About the designated centre

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

No. 2 Seaholly comprises of three detached, and three semi-detached, bungalows. The number of bedrooms in each bungalow ranges from four to seven. Each bungalow has its own garden area. The centre is located on a campus with a number of other designated centres, on the outskirts of Cork city. The centre provides a residential service to 32 people aged between 25 and 65 years old. For the minority of residents this service is provided on a shared care or respite basis. Each resident of No. 2 Seaholly has been diagnosed as functioning within the range associated with a moderate to significant level of intellectual disability. Some residents also have a diagnosis of autism. It is stated in the statement of purpose, that each resident requires full support in activities of daily living.

The following information outlines some additional data on this centre.

Current registration end date:	20/09/2021
Number of residents on the date of inspection:	25

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
25 April 2018	10:00hrs to 17:35hrs	Caitriona Twomey	Lead
24 April 2018	09:15hrs to 18:15hrs	Caitriona Twomey	Lead
24 April 2018	09:15hrs to 18:15hrs	Carol Maricle	Support

Views of people who use the service

Inspectors visited all six units that comprise this designated centre. During these visits some of the residents were attending day services or were engaged in activities elsewhere, while others were at home. The inspectors met with 15 residents in total. Some residents spoke briefly with inspectors, while others were observed as they interacted with each other and support staff.

In general, residents appeared content, well and comfortable with the support they were receiving from staff. They smiled and used body language to indicate their satisfaction.

During this inspection, the inspectors reviewed nine questionnaires completed by staff on behalf of residents. Each questionnaire identified positive experiences for residents living in the centre. Overall, areas that required improvement most often referred to the provision of additional resources.

Inspectors did not receive any questionnaires completed by family members. During the inspection, six family satisfaction surveys (completed as part of the provider's annual review of the centre) were read. These provided feedback on the quality and safety of the service provided. There was one negative comment regarding a meeting scheduled to address an identified issue. The person in charge informed inspectors that this had since been resolved. Overall, family representatives expressed their satisfaction with the service that their relative received in the centre.

Capacity and capability

Overall the inspectors found that some of the governance and oversight arrangements in the centre needed improvement. While there was evidence of good management structures and accountability in the centre these were not effective in ensuring certain areas of service provision were meeting the regulations.

The person in charge had been in this role since October 2017. She was supported in the management of the centre by a sector manager - who acts as a person participating in management, and six full-time unit leaders. Staff spoken with were clear on the lines of accountability in the centre. There were arrangements in place for annual performance management reviews, in addition to staff supervision meetings. There were systems in place to address staff members' training needs. Inspectors reviewed training records of 78 staff working in the centre and identified gaps regarding mandatory training.

The centre was staffed with care workers, social care workers and nurses. The person in charge advised that staff who work in the centre on a relief basis are most often employees of the organisation and are known to residents and the staff team. Night staff working in the centre report to night supervisors, not the unit leaders. This governance arrangement had been flagged as a challenge by some staff during the inspection. The person in charge advised that she had recently begun monthly meetings with night supervisors. This initiative was introduced to support continuity of care.

While it was recognised that there had been an increase in the availability of resources across the centre; however, in some houses the number of staff was insufficient to meet the assessed needs of the residents at all times. For example, in one unit staff reported to inspectors that due to residents' assessed personal care needs, opportunities to support any of the residents to engage in a variety of activities, especially those outside of the centre were limited to two and a half hours in the afternoon. The inspectors also noted that the safe evacuation of residents would be not possible, if required, with this limited staffing resource. In another unit, where staff also facilitated residents' day service activities, staff reported that due to residents' increased, assessed support needs when in the community, it was often difficult to support residents outside the centre. An action from the six-monthly unannounced visit in November 2017 was to complete a review of the staffing in this unit; however, this was not available.

The person in charge and six unit leaders met as a group regularly. Inspectors reviewed a sample of these meeting records from 2018. A variety of relevant topics were covered. Inspectors also reviewed the records of staff meetings held in one of the units, which were occurring frequently. In addition to the sharing of information, these meetings provided opportunities for all staff to raise and discuss any concerns they may have regarding the standard of support provided to residents.

Two unannounced visits and an annual review had been completed demonstrating that there were arrangements in place to monitor the service provided and plans developed to address identified shortcomings. Inspectors found that the service provided was in line with the statement of purpose; however, some amendments were required for this document to meet the associated regulation.

It was identified in the course of the inspection that improved oversight and communication from management was required in some areas of service provision. While acknowledged by the person in charge that there were three inappropriate placements across the centre, staff working in the units believed this number to be higher and were unsure of any plans in place to address this issue. Inspectors found that there was also a lack of clarity regarding responsibility for one resident's day service activities and the oversight provided regarding restrictive practices in the centre. For example, inspectors identified that a physical escort is used in tandem with the use of seclusion for one resident of the centre. The use of this physical restraint had not been notified to HIQA. It was also identified that restricted access to a kitchen in one of the units had not been notified.

Inspectors requested a sample of written service agreements regarding the terms of residency in the centre to reflect the different models of service provided. Although identified as a goal in the annual review, the person in charge and senior management, who attended the feedback meeting, acknowledged that the lack of signed written agreements with residents or their representatives was an ongoing issue. Inspectors saw copies of letters sent to residents' representatives requesting the return of agreements.

In one written agreement reviewed by Inspectors essential information such as the name of the centre, the frequency of residency and fees to be charged were not documented. In addition, a written agreement had not been provided to the representative of a resident receiving respite services in the centre.

Registration Regulation 5: Application for registration or renewal of registration

The provider met the requirements of this regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge met the requirements of the regulations. She had the required experience and had appropriate qualifications in line with the requirements of the regulations. She fulfilled this role for one other designated centre, located on the same campus.

Judgment: Compliant

Regulation 15: Staffing

The staffing complement in some of the units did not assure inspectors that the number of staff was appropriate to the assessed needs of the residents. During this inspection staff personnel files were not reviewed regarding the information and documents specified in Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors reviewed specific training records of 78 staff working in the centre. There was a system in place to ensure new employees of the organisation received appropriate training. Arrangements for refresher training were put in place by the person in charge in collaboration with the organisation's training department; however, these had failed to ensure that staff had completed the required training and refresher training as per the providers policies. There was evidence of the recent introduction of a formal staff supervision system in the centre.

Judgment: Substantially compliant

Regulation 22: Insurance

A review of the insurance documentation submitted with the application to renew the registration of the centre was completed. The provider met the requirements of this regulation.

Judgment: Compliant

Regulation 23: Governance and management

Governance and oversight arrangements in the service failed to ensure that the systems and resource were in place to ensure a safe service and that all residents needs could be met at all times.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

It was identified that there were no signed written agreements in place regarding the terms of residing in the centre for the majority of residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not include all the elements of schedule 1.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had notified HIQA of the occurrence of the majority of incidents that had occurred. However, the provider had failed to notify the Authority of the use of all restrictive practices in the centre.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints procedure and policy in place in the centre. Each unit had their own complaints log. It was acknowledged by senior management that the number of complaints received was low. The person in charge informed inspectors that relatives of two residents had brought their complaints directly to an independent body.

Judgment: Compliant

Regulation 4: Written policies and procedures

Inspectors did not examine this regulation in full. It was identified in the course of the inspection that the provider had not reviewed its policy regarding the use of restrictive procedures and physical, chemical and environmental restraint in over three years.

Judgment: Substantially compliant

Quality and safety

While there was evidence that staff were focused on providing a person centred service and supporting a good quality of life for residents across the centre, residents' experience was varied due to the inconsistent level of resources in some of the houses. Inspectors found that significant improvement was required to the fire precautions and arrangements in the centre. Improvements were also

required regarding staff attendance at mandatory training and the risk register. In one case the dignity of one resident was impacted on by the design of the centre which meant that their bedroom was being used as an access way to a shared bathroom.

All six units were clean, homely and recently decorated in line with residents' needs and preferences. Where there were issues regarding premises, time bound plans were in place to address these.

During the inspection, plans regarding the move of four residents in one unit to a new designated centre in the community were outlined. There was evidence of accessible information provided to residents to support this transition. The staff in this unit reported that a core complement of current staff will support these residents in their new home and outlined goals that residents are being supported to achieve to further support this transition.

Staff who spoke with inspectors were knowledgeable about residents' support needs, preferences and aspirations. Inspectors reviewed the personal plans of a selection of residents. There was evidence of assessment by appropriate healthcare professionals and that the resultant personal plans had been reviewed with input from multidisciplinary professionals, or that this was planned for the near future. Inspectors found that residents' healthcare needs were well met.

There was evidence to show that the registered provider protected residents from abuse. The person in charge had responded to safeguarding concerns, in some instances by relocating residents within the centre. Safeguarding plans that were being implemented across the centre had been developed with input from the organisation's designated officer, demonstrating appropriate oversight. The sample of personal plans reviewed included individualised personal and intimate care plans for residents ensuring that support at these vulnerable times considered residents' personal preferences and dignity.

The provider failed to ensure that suitable arrangements were in place across the centre to meet the needs of each resident as outlined in their personal plans. For example, in a review of the personal goals of two residents living in different units, it was identified that neither resident had achieved their goals that year regarding participation in preferred activities. For another resident, review documentation identified that skills teaching was not being completed in line with that resident's recommended plan. By contrast, in other units there was evidence to support an effective system of goal setting. In addition, while moving within the centre was effective in ensuring some residents' safety from peer to peer abuse, it was not clear that arrangements to meet residents' other needs were in place. For example, following one resident's move to another unit in the centre, inspectors identified shortcomings regarding the continuity, implementation and oversight of that person's day service, and that staff in that unit could now safely evacuate this resident and others if required.

There was also variation across the centre with regards to residents' access to day service and training activities. Some residents attended a day service on a full or

part-time basis, while others were on a waiting list. A number of residents were being supported to participate in day service activities by residential staff. Staff reported challenges regarding their capacity to do this.

There was a risk management policy in place and evidence to support its implementation throughout the centre. During the inspection, some hazards were identified in some units. For example, free access to gloves in units where residents with a history of choking and pica behaviour (eating objects which are inedible) lived. The person in charge advised that these hazards and associated control measures had been identified. However, it was evident that the proposed controls had not yet been implemented. While the majority of risk assessments seen by inspectors were reviewed within the required time frames, those regarding night time observations of residents required attention. Management recognised that the risk register did not include or mitigate all of the centre-wide risks.

Areas for improvement were identified regarding fire precautions in the centre. Inspectors noted the use of a door wedge and furniture to keep fire doors open. These were removed immediately by staff. It was also observed that the closing mechanisms on a number of fire doors were not functioning fully.

Documentation regarding fire was reviewed for one unit in the centre. Fire fighting equipment had been serviced in line with requirements. Following a review of residents' assessed evacuation support needs and fire drill records, inspectors found that provider had not suitably assessed or adequately tested if all residents could be safely evacuated from the centre if there was an emergency, especially in night time conditions. Although staff outlined how they would access additional staff support, this arrangement was not reflected in the unit's evacuation procedure. It was also identified that the Personal Emergency Evacuation Plans for the residents living in this unit required review and improvement. For example, one had limited information regarding the resident's support needs at such a time and another made reference to emergency personnel assisting with evacuation.

Inspectors reviewed the behavioural supports available to residents in a some of the units. In one unit, there was evidence of a behaviour support assessment and plan completed for a resident in recent months. There was also evidence that the effectiveness of this plan was being monitored. In another unit, where seclusion was regularly implemented, improvement was required in the documentation regarding the use of this restrictive practice. While there was evidence of ongoing involvement from the organisation's behaviour support service, the most recent behaviour assessment report and support plan available for this person was dated March 2014. In addition, evidence was not available to show that alternative measures were considered prior to the use of seclusion. The person in charge showed inspectors a proposed new template to record all staff interventions and responses to incidents of behaviours that are challenging.

Restrictive practices were also in use in other parts of the centre. A behaviour standards committee was in place at an organisational level to govern the use of these practices. There were identified gaps in the documented correspondence with this committee. For example, in the oversight, approval and removal of restrictive

practices in the centre. There was also no written record of a response from the provider to a letter from the committee, in May 2017, asking for an update on the implementation of specific recommendations relating to a restrictive practice.

Inspectors reviewed mandatory training records for 78 staff. The number of staff who required or were not booked in to planned training were calculated. It was identified that 10% had not completed fire training, 14% had not completed training in relation to safeguarding residents and the prevention, detection and response to abuse, and that 33% of staff in the centre had not completed training in the management of behaviour that is challenging - including de-escalation and intervention techniques. When reviewing the latter training records, it was also identified that in some cases staff were booked to receive refresher training when full training was required.

Regulation 17: Premises

Overall, each of the units that comprise the centre was clean, bright and decorated in a homely manner.

In one unit, another resident had to pass through another resident's bedroom to access communal bathroom facilities. The person in charge acknowledged that this was not appropriate and showed documentation to evidence that works would be completed by the end of May 2018 to address this issue. It was also identified that the laundry facilities in this unit were not accessible residents.

Judgment: Not compliant

Regulation 20: Information for residents

The residents' guide submitted with the application to renew the registration of the centre was reviewed. While this document included the majority of the information required, it did not set out the three models of residential service provided in the centre.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

There was evidence to support that the person in charge is meeting the requirements of this regulation regarding the planned transition of four residents to

another centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The centre's risk register did not document all of the centre-wide risks identified on inspection and discussed with the person in charge. The identified control measures to mitigate the risk of some hazards had not yet been implemented. In addition, while the majority of risk assessments seen by inspectors were reviewed within the required time frames, some were not.

Judgment: Not compliant

Regulation 28: Fire precautions

Improvements were required regarding fire precautions in the centre. These included maintaining equipment, arrangements for containment and evacuation of all persons in the centre, procedures to be followed in the event of fire, and staff training.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was evidence of the completion of assessments of residents' needs and the timely review of personal plans in line with the regulations. The provider had failed to ensure that arrangements were in place to meet each resident's needs. The provider identified that they were unable to meet the specific needs of some of the residents in the centre.

Judgment: Not compliant

Regulation 6: Health care

There was evidence that the provider was providing appropriate healthcare for each resident with evidence of regular and timely access to general practitioners, other

medical specialists and allied health professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

While there was evidence of good practice, improvement was required to ensure that every effort was made to identify the cause of residents' challenging behaviour, in particular those subject to restrictive practices. Improvement was also required in the documentation of the use of alternative measures so as to ensure the least restrictive procedure is used, and also to evidence that the organisation's behaviour standards committee was fulfilling its oversight objective. Inspectors also identified that the person in charge did not meet the requirements of Regulation 7 regarding staff training.

Judgment: Not compliant

Regulation 8: Protection

There was evidence to show that the registered provider protected residents from abuse. To meet the full requirements of this regulation, some staff required training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for No 2 Seaholly OSV-0004572

Inspection ID: MON-0021185

Date of inspection: 24/04/2018 and 25/04/2018

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Sector manager, Unit Leader and Person in charge on 19 April 2018, carried out the review of staffing in one unit, identified as an action from the last six monthly provider visit. • A review of staffing against care, safety, day supports and social support needs of individual residents will be carried out for all other units [30 September 2018] and • The appropriate risk management plans will be put in place [31/10/2018]	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The services piloted a new system for booking the mandatory trainings of new staff in April 2018 to minimize any potential training gaps in mandatory trainings. This has proved successful and is ongoing. [30 April 2018] • Staff who are employed on a less than full time basis are assigned to certain areas to ensure delivery of continuity of care and for supervision and training purposes [30/09/2018] • Additional trainings in positive risk assessment, ASD and restrictive practices are being delivered in 2018 as part of a continuous professional development programme 26/11/2018.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The Person in Charge will ensure that there are regular audits on internal control systems to ensure safe services and these include checks that :- • A framework is in place to identify, assess and manage all risks in the centre. An annual review was carried out in July 2017 in consultation with residents and their families. • The Person in Charge chairs regular team meetings with the Unit Leaders and night supervisors to ensure information is shared across the teams. Night supervisors will attend at least 4 meetings a year with unit leaders. • The PIC will identify any additional inappropriate placements not already notified to the Services Inappropriate Placement Committee. Each identified inappropriate placement will be risk assessed and included in the Centre's risk register to ensure staff are updated on the progression of the management of this risk. • The Day Service supports and persons responsible for the delivery of these supports will be logged to provide clarity on roles and responsibilities. • An updated audit on restricted practices in the Centre will be carried out and set out in a log for the Centre. This log will be crosschecked against notifications to the authority to ensure completeness of reporting.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • The services will issue additional information to individual residents on (a) the status of the placement i.e. Full time/shared care/respite service and (b)the services included in the financial charge and of additional costs to be borne by the resident • The provider will issue reminders to residents/representative to return signed contracts • The provider will ensure that a contract will issue to resident on respite placement [31 August 2018]	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • The statement of Purpose will be amended to include (a) The services that are currently provided in the designated Centre i.e. Full time placements, shared care and respite services (b) Emergency procedures to be followed in the event of a Fire and (c) Revised floor plans for internal change of access to a bathroom in one unit .3 August 2018]	

Regulation 31: Notification of incidents	Not Compliant

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

- A new PRN reporting form was implemented by the services on the 6th June 2018 to assist unit leaders in the reporting of chemical restraint.
- A restrictive practice meeting was held on 31/03/18 regarding restricted access to one kitchen at times of the day where it is deemed unsafe for the residents to access this area. The Behaviour Standards Committee formally sanctioned this restriction on 16/05/18. This will be reviewed quarterly and notified to the Authority in the Centre's quarterly written report.
- Seclusion is sanctioned by the Behaviour Standards Committee for one resident and is reviewed monthly. The sanctioning form details the use of a transport move to safely escort the resident. This transport move will be notified to the Authority in the Centre's quarterly written report; the next report is due 31/07/18.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

- This September 2017 policy on the use of restrictive practices will be re-issued to all houses in the designated centre to ensure that all teams have the most up-to-date policy.
- The Provider will ensure that all other policies requiring revision are updated and circulated to all staff teams. [30/09/2018]

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

- To comply with regulation 17 the services completed construction works to one property to ensure that a resident enjoys full privacy in their bedroom. It has since been decorated to the resident's preference. The revised floor plan will be notified to the Authority and included in the updated Statement of Purpose
- The access to laundry equipment will be risk assessed in each area and all necessary restrictions will be process in accordance with the Services restricted practices and notified to the Authority. [30/09/2018]

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for

residents:

- The residents guide will be amended to include the services that are currently provided in the designated Centre. Full time placements, shared care and respite services. [17/07/2018

Regulation 26: Risk management procedures	Not Compliant

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

- The services will complete the move to a new upgraded risk management system utilising the HSE risk register template, which will support staff in identifying and rating risks.
- Training staff in the new Risk Management Framework and on risk identification. Assessment and management has commenced.
- Risk assessments are reviewed at a timeframe dependent on the risk rating.
- The PIC met with the Unit Leaders on the 27/06/18, all risk assessments to be reviewed following this meeting. Completed 11/07/18
- Controls to mitigate hazards identified in one house have now been implemented.
- A Risk Identification and Control Pack will be finalised to assist staff in identifying risks and in identifying controls that should be in place in accordance with policy/best practice. This pack will be completed by all units in the Centre to assist in the scheduled reviews of risk in the Centre. [31/10/18]

Regulation 28: Fire precautions	Not Compliant

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

- The Fire wardens in the Centre will ensure that door wedges are not in use and that all fire door closures are kept in working order.

- A separate nighttime evacuation procedure was completed for 1 house on the 23/05/18. A fire drill evacuation was completed under this procedure on 04/06/18 and residents were evacuated in 1 minute 48 seconds.

- Detailed Night Time evacuation procedures will be kept updated for all units in the Centre

- A Fire compliance checklist for staff will issue to all Unit to assist local site-specific staff training and the ongoing monitoring of the necessary Fire Compliance issues. [18/08/2018]

- Staff will all have received the refresher fire training by 08/11/18

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:

- All residents in the center have an individual assessment and personal plan.
- The annual multi-disciplinary review meetings ensure there is clinical oversight on the goals set for residents.
- One residents goals were re-evaluated in a meeting on the 11/07/18 to ensure SMART goals were set and these would be achieved for the coming 12-month period.
- The provider has ensured that arrangements are in place to meet the assessed needs of the residents by ensuring that the Person in Charge and the Team plan for the support requirements against available resources and highlight significant issues using the risk management system.
- The PIC will ensure that the personal plans of residents are supported by the identification of SMART goals and quarterly review of goal progression.
- The Person in Charge will ensure that any barriers to goal achievement are identified on the Centre's risk register and managed in accordance with organisational policy. [30/09/2018]

Regulation 7: Positive behavioural support	Not Compliant

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

- The annual review of the resident's plans will include a review of the therapeutic support required to manage behaviours that challenge, the last such meetings are scheduled for 10/10/18.

- Residents will continue to have regular Periodic service review meetings with multi-disciplinary input, which ensures that the behaviour support plan is implemented including reviewing the proactive/reactive strategies in use for the resident.

- The Reporting of Restricted Practices form will be reviewed to ensure that it records evidence the alternative measures that were trialed prior to a restriction being implemented.

- The Person in Charge and Unit Leaders will receive restrictive practice training/ refresher training [30 September 2018]

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: The Centre will ensure compliance with regulation 8 by: • Awareness training was delivered to the Unit Leaders on safeguarding concerns and zero tolerance [21/02/18]. • Ensure that all staff have received refresher Safeguarding training, remaining staff are booked for 05/09/18, 26/11/18. • Regular Risk Management Meetings will be scheduled and the issue of Safeguarding will form part of the standing agenda.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	19/04/18
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	26/11/18
Regulation 17(1)(a)	The registered provider shall ensure the premises of the	Not Compliant	Orange	07/06/18

	designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	07/06/18
Regulation 20(2)(a)	The guide prepared under paragraph (1) shall include a summary of the services and facilities provided.	Substantially Compliant	Yellow	17/07/18
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/09/18
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	30/09/18
Regulation 24(3)	The registered provider shall, on admission, agree in writing with	Not Compliant	Orange	31/08/18

	each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	18/08/18
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	11/07/18
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	18/08/18
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	04/06/18

	reviewing fire precautions.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	04/06/18
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	04/06/18
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	04/06/18
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	18/08/18 (local site specific) 08/11/18 (general)
Regulation 28(4)(b)	The registered provider shall	Substantially Compliant	Yellow	04/06/18

	ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/07/18
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/18
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief	Substantially Compliant	Yellow	30/09/18

	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.			
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).	Not Compliant	Orange	30/09/18
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/09/18
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	30/09/18
Regulation 07(2)	The person in charge shall ensure that staff receive training in	Not Compliant	IF	30/09/18

	the management of behaviour that is challenging including de-escalation and intervention techniques.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/07/18
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	10/10/18
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 considered before a restrictive	Substantially Compliant	Yellow	10/10/18

	procedure is used.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	10/10/18
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	26/11/18