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

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Goldfinch 4</th>
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</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Brothers of Charity Services Ireland</td>
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<tr>
<td>Address of centre:</td>
<td>Limerick</td>
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<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>24 and 25 April 2018</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0004815</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0021002</td>
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About the designated centre

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

This designated centre consisted of three separate units; a single storey house on its own site and two ground-floor apartments in a large and busy apartment complex. The units were a short drive from each other and their location facilitated convenient access to the day services and all of the social and recreational amenities that the city offered. A maximum of 8 residents could be accommodated; full-time residential services were provided to a cohort of residents with a diverse range of complex needs including physical and sensory disabilities. On a day to day basis care and support was provided by a team of social care staff; ordinarily there was one staff allocated to the house and one staff allocated to the apartments.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>06/09/2018</th>
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<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>7</td>
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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>24 April 2018</td>
<td>09:30hrs to 19:00hrs</td>
<td>Mary Moore</td>
<td>Lead</td>
</tr>
<tr>
<td>25 April 2018</td>
<td>09:15hrs to 15:30hrs</td>
<td>Mary Moore</td>
<td>Lead</td>
</tr>
</tbody>
</table>
Views of people who use the service

There were seven residents living in the centre with a further admission planned. All of the residents attended a day service; the inspector spent time with the residents in both the house and the apartments on the evening of the first day of inspection. Six residents had also chosen to complete the pre-inspection questionnaire provided by HIQA (Health Information and Quality Authority).

Staff had informed residents that the inspector was present and on their return from the day service residents greeted the inspector, introduced themselves and welcomed the inspector into their home. Residents spoke of holidays and events that they had enjoyed and forthcoming events that they were looking forward to. Five residents invited the inspector to view their personal space; photographs led to discussion of family and family events and personal goals achieved. Residents discussed their taste in music and recommended favoured artists to the inspector; residents demonstrated how they had control over their personal space and their personal belongings. A resident who had recently transferred to the centre said that she loved it and was happy to have moved. Overall the feedback received about the centre, staff and quality of life was positive and this would equate with what residents had returned in their questionnaire.

The residents in the apartments did tell the inspector that they had difficulty negotiating the step at the entrance as it was too high for them; one resident said that she would be happy if the inspector could do something to speed up having the step fixed. Another resident said that it would be nice if they had somewhere to sit outside in the apartments.

Capacity and capability

There was a clear governance structure and a defined management team; the inspector was satisfied that the provider did seek to provide residents with a safe quality service and positive aspects of the service were observed. However, the provider had failed to adequately evaluate and respond to data and information available to it; this resulted in an unacceptable level of risk to resident safety and welfare. The provider was requested by HIQA to take action to mitigate against the risk identified within a timeframe set by HIQA. The provider accepted the failing and responded positively and robustly within the specified timeframe.

The management team consisted of the person in charge, the area manager and the
head of community residential services; all were clear on their roles, responsibilities and reporting relationships. The management team had ready access to the support and advice of each other. The provider had taken action to address governance deficits identified at the time of the last inspection; these deficits had at that time impacted negatively on the capacity of the person in charge to effectively govern and supervise the centre.

The person in charge confirmed that she worked fulltime and was no longer required to work as part of the frontline staff team; this allowed her to focus on the operational management of the centre. The person in charge worked shifts that corresponded to times when both staff and residents were in the house; this supported access, communication and supervision. Staff meetings were also convened; residents were free to sit in on these if they wished; a formal system of staff supervision had also been implemented.

The provider completed at the prescribed intervals the provider reviews required by the regulations of the quality and safety of the service; these reports were made available to the inspector. The inspector saw that these reviews were comprehensive and that input from staff, residents and their representatives was sought and incorporated into the review. Each review followed up on the previous action plan and reported satisfactory progress. However, the provider had failed to adequately respond to core data and information as generated by these reviews and from the day to day operation of the centre such as risk assessments, accidents and incidents and simulated evacuation drills. Consequently governance arrangements did not ensure and assure the safety of the service provided to residents. The specific risks related to the design and layout of the apartments, staffing numbers and arrangements and fire safety measures and the collective risk to resident safety that combined, these individual risks created.

The provider had not made appropriate arrangements for staffing the centre. The person in charge described how a core group of staff were employed in the centre; relief staff when required were sourced from a small group of staff that worked in a defined group of designated centres; these arrangements ensured that staff were familiar with residents and that resident’s received continuity in support. However, the inspector was not assured that the provider had systems that ensured that staffing levels and arrangements were adequate and appropriate to the needs of the residents.

There was ordinarily one staff on duty when residents were present; the night-time arrangement was a sleepover staff. In the apartments this one staff was based in one of the two apartments and provided supervision and assistance to residents in the other apartment; this meant that residents in both apartments were unsupervised for periods and there was no staff presence in one apartment at night time. The inspector was not assured based on records seen including the providers own risk assessments that this level of supervision was appropriate to residents needs and adequate to ensure the quality and safety of the service provided. The inspector was advised that factors such as risk assessments did inform staffing levels. The most recent provider of 5 April 2018 stated that all of the residents in the apartments could stay at home and lived independently. However, the inspector saw
that the provider itself had assessed the risk posed to residents by these staffing arrangements and periods without supervision as orange rated (medium) risks.

Additional staff support hours were allocated to the house at weekends; these additional staff supports facilitated social activity and community engagement. However, records seen by the inspector still made intermittent reference to residents requesting more community access, the need for extra staff hours, the cancellation of planned events and the lack of staff capacity to meet individual social needs.

The provider utilised a personal assistance programme where residents paid for personal assistance from a private contractor for social activities and engagement. In the context of the staffing resources available in the centre the inspector was not assured that there was no co-relation between staffing levels and the use of this service. The inspector also found that the use of the personal assistance programme was not implemented in line with the provider’s policy on this. The policy stated that the programme should be used only as an interim measure, that every attempt should be made to meet residents needs from within existing resources, it should not be used for tasks that would be normally undertaken by staff and that there should be a planned phased discontinuation of the service.

Good recruitment practice did promote the quality and safety of the service. A sample of staff files was reviewed by the inspector and was found to be well presented and contained all of the required records such as evidence of Garda Síochána vetting and previous employer references.

There was documentary evidence that staff held suitable qualifications for their role and were provided with education and training by the provider to maintain their knowledge and skills; the training offered to the person in charge reflected her management responsibilities; attendance at mandatory training was monitored. However, there were training deficits in refresher training; one staff required refresher training in safeguarding; two staff required fire safety refresher training.

The inspector reviewed the records of complaints received. The inspector concluded that there was no obstacle to residents raising concerns that they had; one resident said that she knew her concern about the height of the step was written down by staff. Overall for day to day issues there was evidence of the action taken to resolve the issues raised. However, on more substantive matters, while other records seen demonstrated that action was taken to support residents to progress their complaint, this was not adequately reflected in the complaints records themselves.

**Regulation 14: Persons in charge**

The person in charge worked full-time and had the qualifications, skills and
experience necessary to manage the designated centre.

Judgment: Compliant

### Regulation 15: Staffing

The inspector was not assured that the provider had systems that ensured that staffing levels and arrangements were adequate and appropriate to the needs of the residents. In the context of the staffing resources available in the centre the inspector was not assured that there was no co-relation between staffing levels and the use of the personal assistant service. The inspector also concluded that the use of the personal assistance programme was not implemented in line with the provider’s policy on this service.

Judgment: Not compliant

### Regulation 16: Training and staff development

The provider had not made adequate arrangements to ensure all staff had appropriate training. One staff required refresher training in safeguarding; two staff required fire safety refresher training.

Judgment: Substantially compliant

### Regulation 23: Governance and management

While the the provider had systems of review that were in of themselves comprehensive, the provider failed to adequately respond to core data and information as generated by these reviews and from the day to day operation of the centre such as risk assessments, accidents and incidents and simulated evacuation drills. Consequently governance arrangements did not ensure and assure the safety of the service provided to residents.

Judgment: Not compliant

### Regulation 32: Notification of periods when the person in charge is absent

The provider had suitable arrangements for the management of the designated
centre during any absence of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

Overall there was evidence of good complaints management. However, on more substantive matters, while other records seen demonstrated that action was taken to support residents to progress their complaint, this was not adequately reflected in the complaints records themselves.

Judgment: Substantially compliant

Quality and safety

In many areas there were arrangements in place to provide residents with a safe, quality service; residents self reported in their questionnaires and in their engagement that overall they had a good level of satisfaction with their lives in the centre; they articulated the issues that were of concern to them such as accessibility. However, failings identified in staffing arrangements, the design and layout of the building, fire safety measures and the failure of the provider to utilise known data to positively inform and improve the service impacted negatively on the safety of the service provided to residents. This risk was further compounded by the failure to ensure that the assessment of all residents needs was comprehensive.

The inspector saw that assessment of residents needs was not always comprehensive and did not always identify needs and risks such as risk of falls and recurrent health issues that increased the risk of falling. This failure did not provide assurance that the assessment informed and confirmed that the arrangements in the centre were suited to and adequately met the needs of all existing residents and planned admissions. For example one resident with no history of living independently or unsupervised had recently been admitted to the centre when it was known that this level of staff assistance and supervision was not provided in the centre. There was a further planned admission again with no evidence of the evaluation of the suitability and safety of the premises and the available staff supports to meet the residents’ needs, or of how the increased occupancy would impact further on already limited staff resources and associated risks. The provider review of April 2018 had found failings in this regard and concluded that when residents relocated between centres it had to be established that the arrangements were in place to meet the residents needs in the receiving designated including any factors required to mitigate against identified risks. As described above it was not evidenced how this finding informed the most recent admission and the planned
admission to the centre.

Also in the house the inspector found that there was a satisfactory approach to falls prevention and management including multi-disciplinary referral, environmental review, and the provision of assistive aids and equipment. However, this evidence based approach was not consistently applied to all residents at risk of and with a history of falls and injury. This created a preventative deficit and did not provide assurance that systems were in place to prevent falls and injury and provide timely assistance in the event of a fall.

Staff did support residents to access medical review and care and in line with resident choices and preferences staff liaised with 5 different general practitioners (GP). Nursing advice was available from the clinical nurse specialist in age related care; a recent referral for assessment was seen by the inspector. Residents had access to seasonal influenza vaccination and blood-profiling as required was completed by the GP. Residents had access to other health services including psychology, neurology, dental care and optical review; records of referrals, reviews and recommendations were maintained. The inspector saw the implementation of these recommendations such as environmental modifications to support sensory and physical disabilities.

The provider had put supports in place to help resident lead full and meaningful lives and to achieve their goals. Residents were consulted in relation to their care and support; records were personalised and respectful in tone and language. Each resident had a personal planning meeting in which they participated and at which they agreed with staff their personal goals and objectives. There was evidence of the actions taken to progress these goals and that the review of the personal plan was multi-disciplinary.

Each resident attended an off-site day service and participated in a range of activities some of which were community based. Residents’ spoke of a foreign holiday that three of them had enjoyed together supported by staff and hoped to enjoy a further holiday this year. Residents were looking forward to a range of diverse social events such as music, comedy and the regular social attended by peers. Residents enjoyed activities such as swimming, equestrian activities, bowling and dining out. Residents were supported to maintain personal and family relationships that were important to them.

The inspector observed easy and respectful engagement and consultation between residents and staff in relation to routines and choices; in addition to this house meetings were convened. There was discussion on activities and meal choices and more substantive issues such as keeping safe; staff recorded each resident’s participation and contribution and followed up each week on what had been agreed the previous week. The person in charge described how the service of an interpreter was sourced to ensure effective resident consultation and participation in matters of significance to them. Residents described the control they enjoyed over their personal space and personal belongings including their personal finances. One resident had specified that staff were to knock three times on his door before
there was a notice on the door to this effect.

Staff spoken with had a good understanding of safeguarding residents from abuse and both staff and residents had access to support and advice from the designated safeguarding officer, the social worker and the psychology team as appropriate. Staff described actions taken by the provider to ensure that residents were protected from harm and abuse. Staff discussed staying safe, respecting privacy and how to make a complaint with residents; residents said that they would talk to staff either in the day service or in the centre if they had concerns or worries. Records seen demonstrated that residents did raise matters of concern to them and that these concerns were listened to.

Generally residents were described as compatible and this would concur with what the inspector observed on inspection. Residents spoke of having known each other over the years from school and living together.

There was some requirement for guidance on the management of behaviours of concern; this was available and was informed by support and input from psychology and the clinical nurse specialist in behaviour management.

Residents were seen to enjoy routines and an environment that were minimally restrictive. There was one identified environmental practice in the apartments; the isolation of bigger domestic appliances in one apartment as a resident did not use them appropriately without staff supervision. There was an explicit process for its sanction and review and the impact on peers was measured and stated to be minimal.

The designated centre comprised of three premises; one house and two apartments. Overall the inspector was satisfied that the house was suited to the individual and collective needs of the residents. The house promoted accessibility; bathrooms were accessible and well-equipped with hand-rails and grab-rails; a handrail had been fitted in the main hall based on occupational therapy recommendations. The house was well presented and maintained. Refurbishment works were ongoing in the apartments as bathrooms were being converted to accessible wet-rooms; one room was complete and residents were delighted with this and were looking forward to having the other bathroom completed. However, the main entrance to both apartments did not promote accessibility and was not suited to the needs of the current residents and a proposed resident. Residents had complained about this and raised it again with the inspector; the inspector saw that residents slowly and anxiously navigated the step at the entrance. The provider advised that while they owned the property there were potential obstacles to plans to construct the required ramp.

The apartments while adjacent to one another were two separate buildings which meant that given the available staffing levels (one staff), one apartment was generally un-staffed including at night-time. Potentially there was also a direct correlation between the design and layout of the building and staffing arrangements that were not suited to the individual and collective needs of the residents.

Residents had access to a pleasant outdoor area in the house but there was no such
designated area in the apartment complex; one resident had raised this as an issue in their completed questionnaire.

In the context of the design and layout of the premises, staffing arrangements and the existing fire safety measures the inspector concluded that the provider did not have adequate fire safety measures for responding to fire, ensuring that each resident was safe and could be safely evacuated in the event of fire. Given the level of risk identified the provider was requested by HIQA to take immediate action so as to ensure the safety of residents, specifically the occupants of the un-staffed apartment. The provider did respond positively and immediately and took interim action to address and eliminate the risk identified.

The inspector found that the apartments did not have an interlinked fire detection system therefore staff could not in the event of the alarm sounding determine where the fire was located; the detection of fire in the apartment was dependent of staff hearing the alarm; the night-time staffing was a sleepover arrangement. Evacuation was dependent on staff gaining access to the apartment; the final fastenings were two manual locks with the ability for one lock to be secured from the inside which could prevent access to anyone trying to enter. There was a rear escape route but again this was a manual final fastening and led to a secure compact area that could not be readily accessed or vacated due to a high railing. One resident in the apartment consumed tobacco and while staff said that the resident smoked outside there was no risk assessment setting out the controls that ensured it was safe for the resident to smoke and to smoke unsupervised given that the apartment was unstaffed. There was a stale smell of tobacco in the entrance lobby, three lighters and an ashtray with used cigarettes on the windowsill. Neither apartment was fitted with fire resistant doors.

Staff undertook regular simulated evacuation drills with residents. It was of further concern to the inspector to note from the records of these drills that the residents in this apartment could not be relied upon to evacuate independently and had required verbal prompting from staff to evacuate. Both residents had not responded to staff requests to evacuate the apartment during a recent early morning evacuation; staff recorded an evacuation time of ten minutes.

There were also challenges to the effective evacuation of residents in the house. Staff said that one resident refused to evacuate because they were fully aware that it was only a drill. However, there were also infrastructural issues in relation to the use of an inner room as a bedroom. There was evidence in the form of fire resistant doors to protect the escape route that the use of the room as a bedroom had been considered. However, the effectiveness of the fire doors was compromised by the use of the escape route as a utility area. This had been identified and had at the time of this inspection had been referred to the facilities manager.

The provider has policies, procedures and systems for hazard identification and assessment of risk throughout the designated centre and in relation to individual residents. However, these did not demonstrate how they informed, improved and promoted the safety of the service and protected residents from harm and injury. The process of hazard identification and risk assessment was not consistently
applied across the entire designated centre, for example in relation to the failure to evacuate residents. There were mitigating controls that did not reduce the level of assessed risk to residents as they were not implemented in practice, for example the personal alarms provided to residents. Other controls were vague such as the required frequency of staff supervision in the un-staffed apartment. Based on the risk assessments seen by the inspector there were seven open orange rated risk assessments linked to staffing and staffing arrangements; the identified hazards included injury in the centre, injury in the community, unauthorised entry and reduced access to community based activities.

### Regulation 13: General welfare and development

Residents self reported in their questionnaires and in their engagement that overall they had a good level of satisfaction with their lives in the centre. Each resident attended an off-site day service and participated in a range of activities most of which were community based. Residents were supported to maintain personal and family relationships that were important to them.

**Judgment:** Compliant

### Regulation 17: Premises

The entrance to the apartments the did not promote accessibility. Given the available staffing resources the design and layout of the premises was not suited to the individual and collective needs of the residents. A suitable external area was not available to residents in line with their wishes.

**Judgment:** Substantially compliant

### Regulation 26: Risk management procedures

The provider has policies, procedures and systems for hazard identification and assessment of risk throughout the designated centre and in relation to individual
residents. However, these did not demonstrate how they informed, improved and promoted the safety of the service and protected residents from harm and injury.

Judgment: Not compliant

**Regulation 28: Fire precautions**

In the context of the design and layout of the premises, staffing arrangements and the existing fire safety measures the inspector concluded that the provider did not have adequate fire safety measures for responding to fire, ensuring that each resident was safe and could be safely evacuated in the event of fire.

Judgment: Not compliant

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

The assessment of residents needs was not always comprehensive and did not always identify needs and risks such as risk of falls and recurrent health issues that increased the risk of falling. This failure did not provide assurance that the assessment informed and confirmed that the arrangements in the centre were suited to and adequately met the needs of all existing residents and planned admissions. Good practice in relation to falls prevention and management was not implemented consistently.

Judgment: Not compliant

**Regulation 6: Health care**

Staff monitored and responded to residents healthcare needs and requirements. Residents had access to a GP that was acceptable to them and to a range of other healthcare services.

Judgment: Compliant

**Regulation 7: Positive behavioural support**

With input and advice from psychology, psychiatry and the behaviour support specialist, staff supported residents to manage behaviours of concern and risk. The
environment and routines were minimally restrictive; the impact of a restriction on peers was evaluated.

Judgment: Compliant

**Regulation 8: Protection**

The provider had measures in place to protect residents from harm and abuse. These measures included policies and procedures, a designated safeguarding person, staff training and supporting resident awareness of and the skills for self-protection.

Judgment: Compliant

**Regulation 9: Residents' rights**

The inspector saw that residents were consulted with in relation to their care and support; resident choices were respected. The inspector observed easy and respectful engagement and consultation between residents and staff in relation to routines and choices; in addition to this house meetings were convened; staff recorded each resident’s participation and contribution and followed up each week on what had been agreed the previous week. Residents described the control they enjoyed over their personal space and personal belongings including their personal finances

Judgment: Compliant
### Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
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<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 32: Notification of periods when the person in charge is absent</td>
<td>Compliant</td>
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<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
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<tr>
<td>Regulation 13: General welfare and development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Compliant</td>
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<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Compliant</td>
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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. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not Compliant</td>
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Outline how you are going to come into compliance with Regulation 15: Staffing:

- As a mitigation to address fire safety risks and staffing arrangements in place identified during the inspection residents were transferred, following the inspection, from 2 apartments in the designated centre to another registered centre. This transfer took place on 27th April 2018.
- An application to vary will be made in respect of this designated centre to remove the two apartments from the designated centre.
- All risk assessments in the designated center will be reviewed in order to determine if there is adequate staffing in place to adequately mitigate against identified safety risks.
- In the event that this review results in the identification of a requirement for increased staffing support for a particular resident consideration will be given to the ability to meet the assessed needs of the resident within the resources available to the designated centre.
- Where this is possible same will be progressed. In the event that this is not possible a more appropriate placement will be explored in consultation with the resident as outlined in the Individual Service Agreement in place for each resident.
- The current Personal Assistance Service applications (PA1) have been updated and reviewed by the Area Manager, PIC and keyworker in line with the existing Policy on the Use of Personal Assistance Services. This work was completed by 6th June 2018.
- The Personal Assistance Service application form (PA1) will be reviewed quarterly, as per the policy. The review will be conducted by the keyworker in consultation with the individual to ensure they are satisfied with the service and continues to meet the identified purpose of the service.
- The use of Personal Assistance will be limited to supporting individualized activities chosen and approved by residents over and above what can be supported by the BOCSI LR. The use of Personal Assistance to support individualized activities in this manner will be reflected in an updated Statement of Purpose and Function of the Designated Centre in line with the guidance and template issued by HIQA.
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 training that was out of date has been addressed as follows:-
- Two staff member have completed the refresher Fire Safety Training 26/06/2018.
- One staff member will attend Safeguarding Training on 28th July 2018.
- The training department issue a training report on a quarterly basis that will be reviewed by the Area Manager and PIC to ensure that staff who are due for refresher training are scheduled for same as required.

Regulation 23: Governance and management | Not Compliant
---|---
Outline how you are going to come into compliance with Regulation 23: Governance and management:
- The 6th month unannounced report was issued to the Inspector as a draft document during the inspection (24th April 2018). This report had not been formally circulated to the management team for action but was subsequently accepted in full by the Person in Charge.
- Data generated from internal reviews, risk assessment, accidents and incidents and simulated evacuations will be standing order agenda items on the management team’s monthly meetings with a view to ensuring adequate response to this information.
- Escalation of risks within the management structure will take place as per Risk Management procedure if mitigations to address the risk are inadequate.
- As a mitigation to address fire safety risks identified during the inspection residents were transferred, following the inspection, from 2 apartments in the designated centre to another registered centre until such time as a plan to address the deficits in the current house are addressed. This includes layout, fire safety and accessibility.
- An application to vary will be made in respect of this designated centre to remove the two apartments from the designated centre. This will be submitted to HIQA by 6th July 2018.

Regulation 34: Complaints procedure | Substantially Compliant
---|---
Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
- The local operational complaints procedure is a 3 level procedure where issues and complaints raised by residents are addressed at the most local level possible.
- Information pertaining to the resolution of local issues and informal complaints is maintained locally.
- In the event of a more substantive matter which results in a formal complaint
being made the record of actions taken is maintained by the complaints officer.

- As part of the complaints procedure the complaints officer meets with each complainant in the event that a formal complaint is raised.
- A note will be added to the front of each issues raised recording book and each informal complaint book noting the fact that records of actions taken in response to a formal complaint are held by the complaints officer.
- Direction has been issued to all managers on 3rd July 2018 to ensure this action is followed up on.

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Substantially Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 17: Premises:</td>
<td></td>
</tr>
<tr>
<td>• The residents were transferred, following the inspection, from 2 apartments in the designated centre to another registered centre until such time as a plan to address the deficits in the current house are addressed. This includes layout, fire safety and accessibility.</td>
<td></td>
</tr>
<tr>
<td>• An application to vary will be made in respect of this designated centre to remove the two apartments from the designated centre. This will be submitted to HIQA by 6th July 2018.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Regulation 26: Risk management procedures</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</td>
<td></td>
</tr>
<tr>
<td>• The organisation supports positive risk taking in line with resident’s wishes as reflected in its National Risk Management Policy.</td>
<td></td>
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<tr>
<td>• Mindful of the requirement to balance presumption of capacity, the right to choice and quality of life with safety there are occasions where a moderate level risk is deemed tolerable in the context of reasonable mitigations.</td>
<td></td>
</tr>
<tr>
<td>• All assessed risks will be subject to regular review by the Person and Charge to ensure that mitigations in place are adequately robust to promote safety.</td>
<td></td>
</tr>
<tr>
<td>• As a mitigation to address fire safety risks identified during the inspection residents were transferred, following the inspection, from 2 apartments in the designated centre to another registered centre until such time as a plan to address the deficits in the current house are addressed. This includes layout, fire safety and accessibility.</td>
<td></td>
</tr>
<tr>
<td>• An application to vary will be made in respect of this designated centre to remove the two apartments from the designated centre. This will be submitted to HIQA by 6th July 2018.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</td>
<td></td>
</tr>
<tr>
<td>In relation to the apartments:</td>
<td></td>
</tr>
</tbody>
</table>
• As a mitigation to address fire safety risks identified during the inspection, residents were transferred, following the inspection, from 2 apartments in the designated centre to another registered centre until such time as a plan to address the deficits in the current house are addressed. This includes layout, fire safety and accessibility.
• An application to vary will be made in respect of this designated centre to remove the two apartments from the designated centre. This will be submitted to HIQA by 6\textsuperscript{th} July 2018.

In relation to the house:
• Phase I in respect of Fire Safety upgrade (L1 fire alarm and emergency lighting) has been completed and certified in respect of the house in the designated centre.
• A declaration of exemption for planning permission has been received on 6\textsuperscript{th} June 2018 for the change of a window into a door and window in one bedroom. This work will be completed by 31\textsuperscript{st} July 2018.
• As outlined in the letter from the Provider to HIQA on 27\textsuperscript{th} October 2017 resources in respect of funding Phase II fire upgrade works have not been made available. However we continue to seek the appropriate resources required.

<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and personal plan</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

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

• The concerns identified in the Inspection related to residents in the two apartments.
• The residents from the 2 apartments have now transferred to another registered centre that better meets their mobility and care needs. All three residents have current health care plans in place which have been updated since the inspection.
• An application to vary will be made in respect of this designated centre to remove the two apartments from the designated centre. This will be submitted to HIQA by 6\textsuperscript{th} July 2018.
• Residents of the remaining house will be reviewed by their MDT and where there are new healthcare issues identified they will be referred to the relevant healthcare professionals. This will be completed by 30\textsuperscript{th} September 2018.


**Section 2:**

**Regulations to be complied with**

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

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

<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>6tRegulation 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>31st July 2018</td>
</tr>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>28th July 2018</td>
</tr>
<tr>
<td>Regulation 17(1)(a)</td>
<td>The registered provider shall ensure the premises of the</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>6th July 2018</td>
</tr>
</tbody>
</table>
designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

| Regulation 23(2)(a) | 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. | Not Compliant | Orange | 6<sup>th</sup> July 2018 |

| 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 | 6<sup>th</sup> July 2018 |

<p>| Regulation 28(1) | The registered provider shall | Not Compliant | Red | 31&lt;sup&gt;st&lt;/sup&gt; December 2018 |</p>
<table>
<thead>
<tr>
<th>Regulation 28(3)(d)</th>
<th>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.</th>
<th>Not Compliant</th>
<th>Red</th>
<th>31st December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 34(2)(f)</td>
<td>The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>3rd July 2018</td>
</tr>
<tr>
<td>Regulation 05(1)(a)</td>
<td>The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30th September 2018</td>
</tr>
<tr>
<td>Regulation 05(1)(b)</td>
<td>The person in charge shall ensure that a</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30th September 2018</td>
</tr>
</tbody>
</table>
comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

| 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 | 30th September 2018 |