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

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Doon Accommodation Service</th>
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</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>RehabCare</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Kerry</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>29 November 2018</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0005747</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0025787</td>
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</tbody>
</table>
About the designated centre

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

This designated centre was registered in July 2018; the centre was established to provide a community based home for residents transitioning from a larger congregate setting.

The provider aims to provide each resident with a safe, homely environment, encourage independence but also to provide each resident with any support that is required. A maximum of five residents can be accommodated. The provider aims to match the service delivered as closely as possible to resident’s individual requirements through a process of assessment and personal planning. The service operates and is staffed on a full-time basis; the model of support is based on the social model of care.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 4 |
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>
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<tbody>
<tr>
<td>29 November 2018</td>
<td>09:30hrs to 19:30hrs</td>
<td>Mary Moore</td>
<td>Lead</td>
</tr>
</tbody>
</table>
Views of people who use the service

There were four residents living in the centre all of whom engaged with the inspector; three residents recalled the inspector from previous inspections and welcomed the inspector into their new home. Residents said that they were happy in their new home and loved the house; that everything was fine. Residents spoke about their general well-being and the support provided by staff to keep them well. While noted to be busy, the atmosphere was pleasant and positive; residents were clearly familiar with all of the staff on duty and presented as at ease with staff, with their peers and in their environment. Throughout the day residents eagerly came and went with staff to the day service, for walks, to a medical appointment or to complete household errands such as a shopping.

The concept of home was reflected in the way that residents relaxed in the living room (though not together), accessed their bedrooms as they wished and sat and took their meals together.

Capacity and capability

Overall the inspector concluded that the governance of this service focused on the provision of a safe, quality service to residents. The provider had systems of assurance including systems for identifying and managing any issues that compromised either quality or safety. However, a review of staffing levels, of the design and layout of the premises, and of assessment and admission procedures were all required to maximise and assure the appropriateness, safety and quality of the service.

The governance system and how it operated was clear and evidently implemented. Staff spoken with fully understood their individual roles and responsibilities; management and front-line staff articulated a shared common objective of providing each resident with a safe, quality service and understood what this was. Front-line staff were supported and guided by the team leader who in turn reported to the person in charge. The person in charge had responsibility for two designated centres. These services were in close proximity to each other and the person in charge told the inspector that she had the support that she needed from the staff team, from the team leader in each house, from senior management and from the wider organisation to effectively fulfil her role.

There was an out-of-hours on call management system that staff were reported to have accessed. The inspector was advised that this system worked and staff received the support and guidance that they needed. Formal feedback was provided
to the person in charge by the on-call manager each time on-call support was required; this system provided for consistent oversight.

The provider had systems for self-identifying both good practice and areas that required improvement; these systems included the unannounced provider reviews required by the regulations. The time-frame for completion of one of these reviews had not yet been reached (at a minimum six-monthly) but the person in charge had arranged a peer-review of the centre to provide her with a benchmark of how the service was being managed and delivered. The findings of this peer-review were satisfactory. In addition the inspector found other systems that supported quality and safety such as staff meetings, staff supervision, consultation with residents and their representatives and actions to address any deficits that were identified, for example in response to incidents.

The provider did have procedures for managing complaints; however, these procedures while available in an accessible format were not prominently displayed. Three complaints and their management were recorded. From these records the inspector saw that staff supported residents to raise any concerns that they might have; two complaints were deemed to be unresolved and these are discussed again in the next section of this report.

A review was required of staffing levels as there was evidence that they may not have been adequate to meet residents needs and choices at all times; the person in charge had introduced a system to monitor this. Staff spoken with said and records including the staff rota indicated that there were times during the day when there were only two staff on duty. Staff described these specific occasions as challenging as two residents required very close supervision for their ongoing well-being and safety. In addition when there were only two staff on duty individual resident choices had the potential to impact on the choices and routines of the other residents; for example if one resident chose to remain at home as opposed to joining their peers on a community excursion.

There was a team of regular staff employed some of whom had chosen to move to the new service with the residents; there was also a small group of relief staff that worked in the centre. These arrangements ensured that residents received consistent support from staff that were familiar with the residents and their plan of support. Staff spoken with had good knowledge of residents, their plan of support and their individual preferences.

While the inspector did not review training records staff spoken with all confirmed that they had prior to commencing work in the centre completed training including safeguarding, fire safety, responding to behaviours that challenged and medicines management.

**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. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs and of the general operation and administration of the designated centre.

**Judgment:** Compliant

### Regulation 15: Staffing

There were times during the day when there were only two staff on duty and evidence that this was not appropriate to the assessed needs of the residents.

**Judgment:** Substantially compliant

### Regulation 16: Training and staff development

Staff had access to mandatory and required training. Staff were supported in their practice by appraisal and supervision procedures. Staff had the knowledge required of regulatory requirements to ensure that the centre was operated in line with regulatory requirements.

**Judgment:** Compliant

### Regulation 21: Records

The inspector found that the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place. Any records requested were made available; the required information was easily extracted by the inspector from the records; the records were well maintained.

**Judgment:** Compliant

### Regulation 23: Governance and management

While there were areas that required improvement, overall the inspector found the centre to be effectively and consistently governed so as to ensure that each resident received a safe, quality service that was appropriate to their needs. The provider
understood the purpose and benefit of review, had systems of review and utilized the findings of reviews to inform and improve the safety and quality of the service.

Judgment: Compliant

**Regulation 34: Complaints procedure**

The complaints procedure was not prominently displayed.

Judgment: Substantially compliant

**Quality and safety**

The provider aimed to provide each resident with appropriate, safe, quality services in a homely environment with links to and regular opportunity for social inclusion and community involvement. Overall the inspector found that this was achieved; this conclusion was informed by the feedback received from the residents themselves. However, there were areas that needed to be addressed so as to assure both safety and quality. These areas included the design and layout of the building, admission procedures and pre-admission assessments. Improvement in the latter was required as a matter of priority to ensure that the provider had procedures in place that robustly demonstrated that the designated centre was suited to meet the needs of all residents and that the provider had the capacity to meet those needs.

The inspector saw that the care and support provided to residents was based on an assessment of resident needs and a plan of support based on the assessment findings, consultation with residents and recommendations from members of the multi-disciplinary team. There was evidence that residents and representatives were consulted with in relation to any support required. For example one resident showed the inspector his fluid management programme and why it was important for his health to adhere to the programme.

Staff spoken with were familiar with residents required supports including any recent changes and this knowledge provided assurance that there was good communication between staff and daily practice was guided by the personal plan.

While all of the residents engaged verbally there was evidence of supportive tools such as social stories and visual schedules to enhance understanding and support learning. Staff had the knowledge to explain to the inspector at the very start of the inspection the meaning of and how to respond to communication initiated by one resident. This was very beneficial to both the inspector and the resident who readily approached the inspector. The inspector noted that staff sought to promote communication that supported positive social interaction and inclusion for residents.
Residents had some healthcare related needs and were supported by staff to enjoy and maintain good health. Staff said that all residents had a positive relationship with and were happy to attend the General Practitioner (GP) as needed. Each resident had had a full medical review and medicines review post admission. The mental health services had facilitated a home visit for residents post their transition and any ongoing support was provided. Where needs changed, for example in relation to dietary requirements, staff had facilitated the required speech and language review to ensure that residents received care that was evidence based.

The provider had procedures that promoted safe medicines management practice. Staff had completed the required training, a record was maintained of all medicines prescribed and administered; stock balance checks were completed as a system to verify that medicines were administered as prescribed. Residents regularly attended the pharmacy with staff to manage aspects of their medicines regime such as collecting their medicines and paying any fees due.

While the residents presented as a diverse group, staff described them as generally compatible; the inspector saw that residents functioned individually but also worked well together, for example travelling together in the service vehicle and amicably eating together. Staff said that there had been some negative peer to peer interactions post transition but this was now settled; this would concur with notifications received by HIQA (Health Information and Quality Authority).

Residents did present with behaviour that posed risk to their general health and well-being. Staff were aware of the behaviours and the risk and had actions in place to manage both. Staff were working with the behaviour therapist and with residents to manage behaviours in the least restrictive manner through educating residents on the behaviour, its consequence and alternative management strategies. There were some interventions that were identified as restrictive; these were clearly identified as such, each intervention was discussed and agreed as required as a last resort, the impact on others was considered and a date for review of the intervention was agreed. Overall the inspector found that residents currently enjoyed a minimally restrictive environment and routines.

Staff spoken with had good knowledge of safeguarding, how to protect residents from harm and abuse and how to report any safeguarding concerns that arose. Staff described residents as vocal; residents who would say if they felt unsafe; staff also clearly described behaviours that could be indicators of fear or unhappiness. This staff view of residents was reflected in records seen by the inspector including the complaints records referred to earlier. As part of an admission plan there was an identified risk for abuse amongst peers by peers. Two residents had clearly voiced concerns for their personal safety following planned changes to the resident cohort. Residents said that they feared they would be physically hit or would have to witness and endure behaviours that they found upsetting. This raised a further safeguarding concern as residents said that if such was to occur they would physically retaliate.
In the context of these concerns and further concerns raised by staff, the inspector discussed and reviewed records of a proposed admission; the admission process was described as at a pre-transition phase. The provider did have admission procedures and these clearly did consider residents individual and collective needs. There was evidence of regular engagement between all relevant parties and good practice such as providing staff with the opportunity to “shadow” the resident and their current staff team. However, and particularly in the context of the concerns raised and the imminent time-frames, pre-admission assessment procedures did not satisfactorily or robustly demonstrate that the designated centre was best suited to meeting the assessed needs and requirements of the resident or that the provider did and would have the capacity and arrangements in place to adequately, appropriately and safely meet the residents known needs and requirements. The provider did not provide assurance as to how it could adequately and safely meet the collective needs of all residents as their needs were not compatible without impacting negatively on the quality and safety of the existing service that was, based on these inspection findings working well. In addition, it was not robustly evidenced that this planned move was fully in line with the resident’s wishes; the resident was not at the time of this inspection fully engaging with the pre-transition process.

For example, the proposed additional staffing levels were minimal when compared to the staffing levels currently available and required by the proposed resident. It was proposed that the resident would reside in the annexed self-contained apartment but that the apartment was to be left largely unsupervised and without a staff presence; an objective risk based rationale and plan for this was not evidenced. There were proposed restrictive procedures based on segregation of residents from each other to prevent safeguarding incidents; for example no access to the annex from the main house for staff or residents and proposed further environmental barriers to the rear of the property so that residents could not see each other when they accessed the garden and smoking area. While there were proposed procedures for the security of the annex from the main house, it was not demonstrated how existing residents were to protect the security of their own home. The route into and out of the annex was also a designated fire escape route for the main house and this was not considered when discussing proposed and required restrictions.

Staff raised concerns as to the adequacy of the space provided in the annex to meet the residents needs; staff spoken with believed it was not sufficient in this particular instance; it was noted on records seen that feeling restricted may increase the risk of behaviours of concern. This was compounded by space limitations in the main house for residents and staff that general access to the apartment would have resolved. The existing four residents had access to one communal room; staff said that two residents in particular spent a lot of time in their own bedrooms; it was not clear if this was out of personal preference or because they did not have a choice. The main corridor into the kitchen was narrow and the staff office was directly accessed off this. This increased the activity in this constricted area and residents regularly sought to access the office as they constantly passed it. However, staff were seen to keep the office locked when it was both occupied and unoccupied and this did not present as very homely. The office space itself was inadequate and did not provide the space required by a person in charge, a team leader and front-line
staff. It was also the designated staff sleepover room which meant that waking staff did not have routine access to the office on a nightly basis. It was difficult to see how the office and the main house in general could and would support additional staff and administration functions given that they could not be safely accommodated in the annex post admission.

Staff described visits to the centre by families as a positive and inclusive occasion for all residents. However, a suitable private area to receive visitors that was not a resident’s bedroom was not available if required or desired.

Residents were protected by good fire safety management systems. The inspector saw that the premises were fitted with emergency lighting, a fire detection system and fire fighting equipment; there were records available of their appropriate inspection and testing. There were measures for containing fire and smoke; that is fire resistant door-sets with self-closing devices. Staff confirmed that they had completed fire safety training and participated with residents in simulated evacuation drills. Residents participated fully in these and good evacuation times were achieved.

Resident and staff safety was promoted by risk identification and management processes. The inspector saw that the provider had relevant policies and procedures and the person in charge maintained a comprehensive register of work-related and resident specific risks and their management. Staff had signed to confirm that they had read these and staff spoken with described the risk management controls such as specific diet and fluid requirements. However, risks and concerns identified were not adequately and objectively reflected and integrated into the pre-admission process discussed above.

**Regulation 10: Communication**

Staff used tools such as visual schedules and social stories (a tool that supports the safe and meaningful exchange of information) to enhance communication with residents, support meaningful resident consultation, understanding and participation in their required supports.

Judgment: Compliant

**Regulation 11: Visits**

Residents received visitors in line with their choices and preferences. However, a suitable private area to receive visitors that was not a resident’s bedroom was not
Judgment: Substantially compliant

**Regulation 13: General welfare and development**

Residents were facilitated to develop and maintain personal relationships in accordance with their wishes. The provider was proactive in identifying and facilitating for residents opportunities for engagement and for participation in the wider community. There was evidence of an individualised approach to support and consideration of the suitability of programmes to each individual. Residents presented as content and reported satisfaction with their life in and outside of the centre.

Judgment: Compliant

**Regulation 17: Premises**

There were space limitations in the main house particularly in relation to circulation areas and communal space; residents shared one communal space and this was not always suited to their individual needs and preferences.

The available office space was inadequate and did not provide the space needed for a person in charge, a team leader and front-line staff. It was also the designated staff sleepover room which meant that waking staff did not have routine access to the office on a nightly basis.

Judgment: Substantially compliant

**Regulation 26: Risk management procedures**

Where the pre-admission assessment identified risks and concerns, they were not adequately and objectively reflected and integrated into risk management and pre-admission procedures.

Judgment: Substantially compliant

**Regulation 28: Fire precautions**
The provider had effective fire safety management systems in place including arrangements for the safe evacuation of residents.

Judgment: Compliant

**Regulation 29: Medicines and pharmaceutical services**

The provider had measures that ensured that residents were protected by safe medicines management. There were systems for responding to any medicines related incidents; there was evidence of corrective action to prevent re-occurrence.

Judgment: Compliant

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

Pre-admission procedures did not satisfactorily or robustly demonstrate that the designated centre was best suited to meeting the assessed needs of the resident or that the provider did and would have the capacity and arrangements in place to adequately, appropriately and safely meet the residents known needs and requirements.

It was not robustly evidenced that this move was fully in line with the resident’s wishes; the resident was not at the time of this inspection fully engaging with the pre-transition process.

The provider did not provide assurance as to how it could adequately and safely meet the collective needs of all residents as their needs were not compatible without impacting negatively on the quality and safety of the existing service that was, based on these inspection findings working well.

Judgment: Not compliant

**Regulation 6: Health care**

Staff assessed, planned for and monitored residents healthcare needs. Each resident has access to the range of healthcare services that they required. Residents were consulted with in relation to the care that they required and that promoted
their health and well-being.

Judgment: Compliant

**Regulation 7: Positive behavioural support**

There was evidence of a positive approach to the management of behaviour as staff sought to educate and work with residents in the implementation of preventative therapeutic interventions. The behaviour management approach and plan was tailored to individual needs.

There was policy, procedure and oversight of the use of restrictive practices; currently these were minimal.

Judgment: Compliant

**Regulation 8: Protection**

As part of an admission plan there was an identified possible risk for abuse amongst peers by peers. Two residents had clearly voiced concerns for their personal safety. A further safeguarding concern was that residents said that in such situations they would physically retaliate.

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

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<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>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<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 10: Communication</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 13: General welfare and development</td>
<td>Compliant</td>
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<tr>
<td>Regulation 17: Premises</td>
<td>Substantially compliant</td>
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<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 29: Medicines and pharmaceutical services</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Not compliant</td>
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Compliance Plan for Doon Accommodation Service OSV-0005747

Inspection ID: MON-0025787

Date of inspection: 29/11/2018

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. 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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<tbody>
<tr>
<td>Regulation 15: Staffing</td>
<td>Substantially Compliant</td>
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Outline how you are going to come into compliance with Regulation 15: Staffing:

Background
Staff are recruited to the service in line with organisational policy. The staffing levels provided in the service are based on the assessed needs of residents.

Actions
To reduce the risks around meal times, aid community activities and enable lunch breaks, staff Rota to be amended to include 4 staff daily. PPIMs to address same with HSE to be completed 31/01/2019.

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<thead>
<tr>
<th>Regulation 34: Complaints procedure</th>
<th>Substantially Compliant</th>
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Background
- All complaints are recorded on RehabCare’s online reporting system and the organisation’s policy guidelines are followed locally. The Complaints Policy and Procedure is discussed regularly in house meetings, including what to do if the complainant is not happy with the outcome of their complaint. The procedure is clearly outlined and advertised in the house and all residents have signed this document as evidence of their involvement in its discussion.
## Action
- Complaints procedure easy read visual is displayed on notice board in the hallway and was discussed with residents in a house meeting. This was complete on 14.12.2018.

<table>
<thead>
<tr>
<th>Regulation 11: Visits</th>
<th>Substantially Compliant</th>
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<tbody>
<tr>
<td><strong>Outline how you are going to come into compliance with Regulation 11: Visits:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td>RehabCare is committed to ensuring that residents are facilitated to receive visitors in their homes. Residents are facilitated to ensure they are supported to maintain relationships with families and friends.</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>Architect to visit property by 1st February 2019, plans will be drawn up thereafter in order to facilitate the addition of a space where residents can receive visitors. An extension of existing space will be completed to be fitted 31st May 2019. This will provide an additional room for visitors.</td>
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<tr>
<th>Regulation 17: Premises</th>
<th>Substantially Compliant</th>
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<tbody>
<tr>
<td><strong>Outline how you are going to come into compliance with Regulation 17: Premises:</strong></td>
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<tr>
<td><strong>Background</strong></td>
<td>The organization is committed to ensuring that the designated centre is decorated and maintained to a high standard. Residents are encouraged and supported by staff to input into the decor their own home.</td>
</tr>
<tr>
<td><strong>Actions</strong></td>
<td>Staff Office is to be relocated to upstairs bedroom and what is currently the office will become the resident’s bedroom. This action will be completed by 28.02.2019. The Statement of Purpose will be updated with revised Floor Plans with blue and red markings indicating the changes in the service layout. This will be complete by 28.02.2019. Guidance will be sought from HIQA in relation to this process. The PPIM to review the possibility of adding a conservatory to the rear of the kitchen offering a second reception area, visitor’s area or quite space when required. Review to be completed by 28.02.2019</td>
</tr>
</tbody>
</table>
- Architect to visit property by 1\textsuperscript{st} February 2019, plans will be drawn up thereafter in order to facilitate the addition of a space where residents can receive visitors.
- An extension of existing space will be completed/fitted 31\textsuperscript{st} May 2019.
- This will provide an additional room for visitors

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<tr>
<th>Regulation 26: Risk management procedures</th>
<th>Substantially Compliant</th>
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

**Background**
RehabCare operate a robust risk management system. Processes are in place for the identification, assessment and review of risk to ensure adequate control measures are in place to manage all risks. Risk management practices aim to protect the safety and respect the rights of service users.

**Actions**
- The service has commenced a pre transition process to assess and determine the suitability of a service in the annex to meet resident needs.
- Behavioral therapist working with Team Leader, PPIM and PIC to devise and implement robust risk assessment and associated control measures specific to any new resident who may transition into the annex in the future. The pre transition phase to determine suitability will be completed by 30/06/2019.
- Risk assessment to be implemented regarding fear of two residents. To be completed by 31/12/2018.
- Independent advocates to be sourced for residents.
- Controls and supports identified in that risk assessment will be implemented in order that they address and alleviate those fears.

These will also form part of the pre transition plan and decisions made for any person referred to the service.

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<tr>
<th>Regulation 5: Individual assessment and personal plan</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

**Background**
There is an annual screening of Resident needs, this informs the support plan which identifies their support needs and guides staff practice. The Resident is also supported...
to have ongoing action plans which enable them to pursue their goals. Based on the ethos of person centred planning, Support Plans and Action Plans are developed in consultation with the resident. Plans are reviewed on an ongoing basis to review their effectiveness and there is formal review at minimum on an annual basis. The review looks at the effectiveness of the plan over the previous 12 months and encourages the resident to identify goals for the coming year.

**Action**

- Meeting to be held with key stakeholders to review existing pre transition plan. This will review evidence of risk and inform the development of risk assessments to outline controls measures that may be required to facilitate any pre transition plan. To be completed by 08/02/2019.
- Any person referred will be assessed in terms of their ability and support needs required to comply with the fire evacuation plan. To be implemented within the pre transition time frame.
- Pre transition plan to include evidence of the following:
  - Evidence that the environment, space internally and externally are consistent with the needs of the individual.
  - Exposure and practice of drills,
  - Day visits to house/annex, to be set down by PIC in order that full information and experience can be measured.
  - Experience of meal times, evenings and community outings within and from the residence. This will need to assure the provider that the residence is suited to the person referred.
  - Staffing requirements and transport resources, to be identified during the pre-transition phase.
  - Set date to be given to pre transition period. This will be a maximum of a 4 months period from start to finish.
  - The provider will ensure that the residence is suited to the needs and capacity of the referred person.
  - Any issues that arise during the pre-transition plan will be reviewed monthly and assessed specifically in terms of suitability of the proposed placement.
  - The provider holds the right through the admission procedure to decline a move to transition if the above are not met.
  - The provider upholds the safety of all residents and will not proceed with an admission that they believe will compromise this.
  - All future residents will be expected to participate in the pre transition phase. If this does not occur there will be no admission.
  - The provider will ensure that adequate staffing and governance are given to all new residents.

| Regulation 8: Protection | Not Compliant |
Outline how you are going to come into compliance with Regulation 8: Protection:

Background

The organisation’s Positive Behaviour Support and Restrictive Practices Policies guides staff practice when supporting Residents in this regard. Organisational policy requires that all staff must complete a 2-day MAPA Foundation course and an annual refresher thereafter throughout their employment with RehabCare. This training equips staff with the skills required to support Residents who experience behaviours that challenge.

Behaviour management plans are in place where necessary and staff are knowledgeable and competent in the implementation of these plans. These plans are periodically reviewed and monitored to ensure they are meeting the needs of the Resident.

All restrictive practices must be approved by a Restrictive Practice Committee and are monitored and reviewed to ensure they are in place for the shortest duration possible.

Actions

• Meeting to be facilitated with advocate regarding verbal feedback from two residents. To be completed by 31/01/2019.
• Safe guarding plan to be implemented if required, to be completed by 28/02/2019.
• Pre transition plan to be adapted as needs be in relation to the concerns raised, these concerns will be given the required consideration as part of any proposed pre transition.
• Advocates to work with individuals, residents and referred residents to ensure compatibility and safety of all concerned.
• Control measures to be implemented if required.
• The provider will reserve the right to refuse admission on the grounds of safety and protection should any concerns in this regard become apparent through the assessment phase.
## Section 2:

### Regulations to be complied with

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

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

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 11(3)(b)</td>
<td>The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident’s room, is available to a resident in which to receive a visitor if required.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>28/02/2019</td>
</tr>
<tr>
<td>Regulation 15(1)</td>
<td>The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/01/2019</td>
</tr>
</tbody>
</table>

Regulation | The registered | Substantially | Yellow | 28/02/2019 |
<table>
<thead>
<tr>
<th>Regulation</th>
<th>Provider requirement</th>
<th>Status</th>
<th>Color</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>17(1)(a)</td>
<td>Provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.</td>
<td>Compliant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Regulation 34(1)(d)</td>
<td>The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>14/12/2018</td>
</tr>
<tr>
<td>Regulation 05(2)</td>
<td>The registered provider shall ensure, insofar as is reasonably practicable, that</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/06/2019</td>
</tr>
</tbody>
</table>
arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).

<table>
<thead>
<tr>
<th>Regulation 05(3)</th>
<th>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).</th>
<th>Not Compliant</th>
<th>Orange</th>
<th>30/06/2019</th>
</tr>
</thead>
</table>

| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 30/06/2019 |