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

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Caislean</th>
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</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Brothers of Charity Services Ireland CLG</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Clare</td>
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<tr>
<td>Type of inspection:</td>
<td>Short Notice Announced</td>
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<tr>
<td>Date of inspection:</td>
<td>29 October 2020</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0005361</td>
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<tr>
<td>Fieldwork ID:</td>
<td>MON-0030881</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.

Caislean is a centre run by Brothers of Charity Services Ireland. A full-time residential service is provided for a maximum of two residents, both of whom must be over the age of 18 years with mild to moderate assessed needs. The centre is located in a town in Co. Clare in proximity of the services and amenities offered by the busy town. The house is a two-storey premises where residents have access to their own bedroom, some en-suite facilities, shared bathrooms, communal areas, a relaxation room and garden area. While residents present with a broad range of needs the model of support is social and staff are on duty both day and night to support the residents who live in the centre. Day to day management and oversight of the service is delegated to the person in charge supported by a social care worker.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 2 |
How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (hereafter referred to as 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>
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<tbody>
<tr>
<td>Thursday 29 October 2020</td>
<td>09:45hrs to 16:30hrs</td>
<td>Mary Moore</td>
<td>Lead</td>
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What residents told us and what inspectors observed

Mindful of the need to minimise the risk of the introduction of and onward transmission of COVID-19 the inspector minimised the amount of time spent with both residents and staff while maximising the opportunities to meet with both groups, discuss and observe practice. The inspector met with both residents at the start and end of the inspection and briefly during the inspection. Both residents primarily communicate using non-verbal methods such as by gesture and facial expression and both residents indicated that they were ok with the presence of the inspector in their home. One resident used a communication application that was designed specifically for them by staff and used this to communicate with staff when discussing plans and preferred activities for the day. Unfortunately many of the chosen activities were unavailable due to COVID-19 restrictions but this did not result in any evident distress or anxiety and the resident and staff discussed possible alternatives. COVID-19, its impact on residents lives and the change needed in response to the support provided informed much of the discussion and findings of this inspection. This will be discussed in the main body of the report, for example in relation to staffing resources. As the day progressed residents demonstrated their comfort with the inspector as they invited the inspector to assist them with activities at hand; again in the context of COVID-19 it was explained to residents how unfortunately, to protect them, the inspector could not join them. This and other gestures of warmth such as wishing to say good bye by physical gesture indicated how reliant residents were on staff and others to keep them safe from the risk of COVID-19; staff reacted calmly as they reminded residents to use their alternative forms of greeting. The practice and routines observed were as described by staff. Staff were informed on speaking with them about residents, their needs, their plans of support and current challenges to ensuring both residents received a safe, quality service. The house looked well having undergone recent essential works to repair damage caused by a faulty drain.

Capacity and capability

This centre has had challenges in 2020, firstly in responding to and managing the risk posed to such services by the COVID-19 pandemic, and secondly the requirement to relocate to another designated centre while the repair work referenced above was undertaken. Staff and residents had moved back into the house in the weeks preceding this Health Information and Quality Authority (HIQA) inspection. Managing this transition, supporting residents during it and the relatively recent move back possibly impacted on these inspection findings. However, notwithstanding this transition the deficits identified by this inspection also indicated a possible deficit in the capacity of the management structure to respond to and manage such challenges whilst also ensuring effective oversight and good regulatory
compliance. This inspection found that sufficient staff resources were not allocated to the centre at all times given that needs, routines and plans of support had to change in response to COVID-19. There clearly was evidence of management and oversight and deficits such as the staffing deficit were identified. Information and systems were however somewhat fragmented and not collated in a way that robustly demonstrated the impact of change and insufficient resources on the quality and safety of the service. For example, changing needs that presented new risks, then the challenge of responding to these needs and risks safely and therapeutically in the absence of the required resources. These matters were all evident as standalone issues but the lack of structured, integrated oversight did not provide assurance as to how the impact on quality and safety was robustly captured so as to inform the change and improvement that was needed.

For example, the inspector reviewed reports of internal audits of the quality and safety of the service completed in 2019-2020. The inspector saw that feedback from residents and their representatives was actively sought, with staff detailing how residents used words, gestures and communication applications to communicate their views on life in the centre. The feedback provided informed the findings and action plans of these reviews. An overarching centre specific plan monitored the progress made on any required actions and their impact on the quality and safety of the service. Overall these audits and their findings reflected a well managed service where residents were in receipt of a safe, quality service. However, no review or quality improvement plan seen by the inspector reflected the findings of this HIQA inspection for example in relation to complaints management, staffing levels, risk management and the planning and review of personal support. The findings of the most recent internal review may have been compromised by the desk-top format that was utilised as an infection prevention and control measure.

Furthermore, the inspector reviewed the management of a complaint that was also reviewed as part of the recent internal review; no deficit was identified in its management by that internal review. However, the inspector found that the complaints policy and procedure including the procedure displayed all needed updating as they did not contain up-to-date information. The actions to be taken in response to the complaint so as to resolve it were listed but one, a planned face-to-face meeting was not complete due to COVID-19 restrictions. It was however recorded and reported to the inspector that the matter was resolved to the satisfaction of the complainant; how this satisfaction was established, tested and confirmed was not adequately evidenced.

The number of staff on duty was not always sufficient to meet the changing needs of residents; this impacted on the quality and safety of the service provided to both residents. The documenting of this deficit and its impact on the service was fragmented and not progressed in a way that indicated that there was a planned and timely resolution. The evidence to support this finding was evident in minutes of meetings, minutes of accidents and incidents and on speaking with staff. The needs of one resident and how these needs presented had changed, most likely in response to dramatically changed routines and limited social opportunities in response to COVID-19. There was only one staff on duty at times and this was not sufficient to provide the support and diversion that was needed by both residents in
response to periods of anxiety or indeed to prevent such periods and their escalation. Currently the provider was attempting to maximise evening staffing levels by reducing morning staffing levels. Based on the sample of staff rotas seen this reduction in morning staffing levels allowed two staff to be on duty up to 21:30 three evenings each week. The redistribution of resources from morning to evening did not address the daily deficit of three staffing hours identified by the person in charge. When residents experienced periods of anxiety and there was only one staff on duty, staff were challenged to provide both residents with the supervision, support and reassurance that they needed. Staff could not provide diversions to prevent and alleviate the anxiety, such as a social drive or a walk as both residents would have to travel while one of them was in an anxious state. This will be discussed again in the next section of this report in the context of risk assessment and behaviour support.

Staff had access to a programme of education and training that equipped them with the skills needed to provide residents with safe, effective care. Based on the sample of records seen all staff had completed mandatory, required and desired training such as safeguarding, medicines management and first aid. Staff had also completed training on care interventions specific to residents in this centre. The training programme was responsive to the COVID-19 pandemic and all staff had completed modules such as hand-hygiene, breaking the chain of infection and how to correctly use personal protective equipment.

**Regulation 14: Persons in charge**

The person in charge worked full-time and had the qualifications, skills and experience needed to manage the designated centre. It was evident that the person in charge was informed, monitored the quality and safety of the service and taking into account their role in the governance structure escalated concerns that arose.

**Judgment:** Compliant

**Regulation 15: Staffing**

The number of staff on duty was not always sufficient to meet the changing needs of residents; this impacted on the quality and safety of the service provided to both residents.

**Judgment:** Substantially compliant

**Regulation 16: Training and staff development**
Staff had access to a programme of education and training that equipped them with the skills needed to provide residents with safe, effective care. The training programme was responsive to the individual needs of the residents and to change such as the COVID-19 pandemic.

<table>
<thead>
<tr>
<th>Regulation 23: Governance and management</th>
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<tr>
<td>The deficits identified by this inspection indicated a possible deficit in the capacity of the management structure to respond to and manage challenges such as the recent transition to another location, whilst also ensuring effective oversight and good regulatory compliance. This inspection found that sufficient staff resources were not allocated to the centre given that needs, routines and plans of support had to changed in response to COVID-19. There was evidence of management and oversight and deficits such as the staffing deficit were identified. Information and systems were however fragmented and not collated in a way that robustly demonstrated the impact of change and the insufficient resources on the quality and safety of the service. For example changing needs that presented new risks, then the challenge of responding to these needs and risks safely and therapeutically in the absence of the required resources. These matters were all evident as standalone issues but the lack of structured, integrated, effective oversight did not provide assurance as to how the impact on quality and safety was robustly captured so as to inform the change and improvement that was needed.</td>
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<td>Judgment: Substantially compliant</td>
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<th>Regulation 3: Statement of purpose</th>
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<td>The inspector saw that the statement of purpose was available in the centre. The information in the record such as details of the management structure was kept up to date.</td>
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<td>Judgment: Compliant</td>
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<table>
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<tr>
<th>Regulation 34: Complaints procedure</th>
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<tbody>
<tr>
<td>The complaints policy and procedure including the procedure displayed all needed updating as they did not contain the up-to-date information. While it was recorded</td>
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and reported to the inspector that a complaint was resolved to the satisfaction of a complainant, how this satisfaction was established, tested and confirmed was not adequately evidenced.

Judgment: Substantially compliant

Quality and safety

It was evident that management and staff sought to provide both residents with a safe, quality service that was appropriate to their needs. For example, the provider had invested in the repair and refurbishment of the property and residents returned to a pleasant and welcoming home. Staff were very aware of the impact on residents of change including the restrictions required to curtail the spread of COVID-19. However, COVID-19 had brought significant change to how residents had lived their lives with staff describing it as if everything residents had known and enjoyed had been pulled from them. This change in routine and choices resulted in increased needs that were not always adequately met by the available staffing resources. Therefore, despite the will and commitment of the staff team, the quality and safety of the service provided was limited by and negatively impacted on because there were not enough staff on duty at all times.

For example, the impact of change on residents was expressed in behaviour linked to anxiety. Incidents were monitored and these records showed that overall both the frequency and intensity of episodes of acute anxiety had increased as residents were challenged to cope with ongoing change. Records seen indicated that residents had access to psychiatry and behaviour support and the positive behaviour support plan guided staff on the preventative and responsive strategies to be used. A behaviour support plan specifically to support both residents during their recent temporary move out of the centre had also been developed. However, there was a requirement for timely, further review of the plan, by an appropriate person in consultation with the staff team. This review needed to take into account the impact of inadequate staffing resources, the altered presentation and rapid escalation of the anxiety as clearly noted and documented by staff who were familiar with the resident. Staffing levels limited the ability of staff to maximise therapeutic interventions referenced in the primary plan such as going for a walk or a social drive and other records seen reported the reintroduction of and increased use of less therapeutic interventions including medicines prescribed to be used on an as needed basis. While the provider sought to reallocate staffing resources to times where increased anxiety was possible, the current staffing levels and arrangements did not provide for the flexibility of routines and response that 1:1 staffing could provide. Staff spoken with were clear that it was not just about being able to leave the centre if this was what was needed by the resident, but being able to provide both residents with the individualised support they needed when such periods of anxiety developed.
It was clear that the importance of identifying and managing risk was understood. A register of risks, their assessment and management was maintained and the register had been updated to reflect change and new risk to resident and staff safety such as the risk of COVID-19. However the process of risk management was fragmented, and risks and their management were not linked where there was an evident correlation between risks. The role of staffing as a control, adequate staffing levels and deficits in staffing levels and how these impacted on the reduction or increase in risk was not robustly evident in the sample of risk assessments reviewed. Records of incidents including behaviour incidents were maintained and analysed and while this analysis produced relevant information it was no evident how this information informed the assessment of residual risk. For example, it was not evident how the staffing deficit impacted on the ability to control other identified risks such as the risk for a resident leaving the centre without staff, the risk of choking, the risk for safeguarding vulnerability if adequate supervision could not be provided. Records seen indicated that the frequency of the locking of the front door had increased so it is reasonable to conclude that the risk had increased. Likewise while the frequency, intensity and presentation of behaviour had increased with staff recently recording that they felt unsafe, the residual risk rating for lone working remained very low. Collectively these findings did not provide robust assurance that residual risk in the centre was accurately measured and adequately controlled.

Staff spoken with were clearly familiar with the needs, wishes, care and support of both residents. It was also evident from speaking with staff and from a range of records seen such as the report of the recent internal review and minutes of staff meetings that staff were very aware of how residents routines and lives had changed as a result of COVID-19. It was evident that staff sought to find ways of keeping residents active and engaged, well and happy while also keeping them safe from the risk of COVID-19. The inspector saw that staff sought to provide an individualised service to each resident because while residents lived compatibility together they had different needs, interests and abilities. However, the personal plan reviewed by the inspector did not adequately reflect the efforts made by staff, the strategies adopted by them in response to altered routines, diminished social and community opportunities and personal goals that could not be progressed.

Records seen indicated that staff monitored resident well-being and sought advice and review as needed from the relevant clinician such as the General Practitioner (GP), psychiatry, behaviour support, speech and language therapy and hospital based services. Staff maintained records of these consultations and any advice and recommendations made. However, while there were healthcare specific plans of care these were not updated in line with any changes made; this is addressed above when discussing the personal plan in general. One indicator of adherence to and the effectiveness of the plan was the maintenance of a stable body weight. Staff monitored body weight and these records provided assurance that the recommended therapeutic range was met by the care provided.

However, there was a requirement for clarity, clear protocols and contingency plans that were adhered to in practice where symptoms of illness arose that raised an index of suspicion of suspected COVID-19. These protocols were required as recognition of symptoms including atypical symptoms and timely intervention such
as restricted movements and-or isolation are pivotal to protecting others and preventing the onward transmission of COVID-19. Two narrative records seen by the inspector and discussed with management of the service did not evidence that such protective measures had been taken in such circumstances, that is where there were symptoms and an index of suspicion. In addition the inspector found that recently revised guidance issued to staff was not clear in its guidance in relation to raised body temperature as a possible indicator of COVID-19 and the action to be taken in response to a range of temperature readings. For example, staff were advised not to enter the premises if they had a fever and they should recheck their temperature after a period of time. It was not clear however in the guidance what the purpose of the second reading was and what staff should do if the second reading no longer indicated a fever. Such gaps in policy and practice created a risk that the many other infection prevention and control measures evident would fail to protect residents and staff from the accidental introduction and onward transmission of COVID-19. The controls observed included the use of face masks by staff, efforts to educate residents in both the use of face coverings and performing hand hygiene, the regular cleaning of contact points and the updating of the risk register, for example so that safe visiting could be facilitated where this was critical to resident psychosocial well-being.

The provider had effective fire safety measures. Simulated evacuation drills with undertaken by staff and residents, the drills will convened to replicate different scenarios including minimum staffing levels. Staff participation in these drills was monitored and this ensured that all staff participated in a drill. Each resident had a personal emergency evacuation plan (PEEP) and while both residents required prompting and direction from staff, records seen demonstrated that both residents could be evacuated safely and quickly. The premises was equipped with a fire detection and alarm system, emergency lighting, fire fighting equipment and doors designed to contain the spread of fire and its products. There were certificates confirming the inspection and maintenance of these systems at the required intervals, However, the fire resistant doors were not fitted with self-closing devices.

### Regulation 10: Communication

Both residents communicated primarily using non-verbal methods. Staff maintained good records of how residents were consulted with and how they provided feedback and made their preferred choices using gestures, words, facial expressions, manual signing, visual prompts such as choice boards and technology including communication applications.

**Judgment: Compliant**

### Regulation 17: Premises
The provider had completed recent construction works to repair an external problem that had caused internal damage. The inspector saw that the premises had been refitted and redecorated once the repair work was completed.

**Judgment:** Compliant

**Regulation 26: Risk management procedures**

Deficits in and a fragmented approach to risk identification, management and review did not provide robust assurance that residual risk in the centre was accurately measured and adequately controlled.

**Judgment:** Substantially compliant

**Regulation 27: Protection against infection**

There was evidence of much practice that was aligned with national policy and guidance. However, there was a requirement for clarity, clear protocols and contingency plans that were adhered to in practice where symptoms arose that raised an index of suspicion that these symptoms were suggestive of suspected COVID-19. Gaps in policy, guidance and practice created a risk that the many other infection prevention and control measures evident would fail to protect residents and staff from the accidental introduction and onward transmission of COVID-19.

**Judgment:** Substantially compliant

**Regulation 28: Fire precautions**

Doors to contain fire and its products such as smoke were provided for but they were not fitted with self-closing devices.

**Judgment:** Substantially compliant

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

The personal plan reviewed by the inspector did not adequately reflect the efforts made by staff, the strategies adopted by them in response to altered routines,
diminished social and community opportunities and personal goals that could not be progressed as a result of living with COVID-19.

Judgment: Substantially compliant

### Regulation 6: Health care

Staff monitored resident health and well-being and ensured that residents had access to the care and services that they needed and as appropriate to their needs.

Judgment: Compliant

### Regulation 7: Positive behavioural support

There was a requirement for timely, further review of the behaviour support plan by an appropriate person in consultation with the staff team. The review needed to take into account the impact of inadequate staffing resources, the altered presentation and rapid escalation of the anxiety as clearly noted and documented by staff who were familiar with the resident. Staffing levels limited the ability of staff to maximise therapeutic interventions referenced in the primary plan such as going for a walk or a social drive and other records seen reported the reintroduction of and increased use of less therapeutic interventions such as medicines prescribed to be used on an as needed basis.

Judgment: Substantially compliant

### Regulation 8: Protection

There was no identified safeguarding concern. Where the assessed needs of residents made them more vulnerable to abuse this was identified and addressed in the personal plan. Each resident also had an easy read safeguarding communication booklet that was designed specifically for them and discussed with them by staff. Training records indicated that all staff had completed safeguarding training. How to contact the designated safeguarding officer was prominently displayed.

Judgment: Compliant

### Regulation 9: Residents' rights
Overall the inspector found that the day-to-day operation of this service was focused on residents, their needs and choices. For example as mentioned above staff were diligent in recording how residents were consulted with, participated in decisions and expressed their choices and preferences on a daily basis and during more structured engagements. The provider operated an advocacy forum and residents in this centre were represented by a peer advocate. Staff were very aware of the impact of national restrictions designed to curtail the spread of COVID-19 on residents rights and choices and sought to offer alternatives or facilitate some choices safely such as access to family where this was critical to resident well-being.

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

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></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>
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<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</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 10: Communication</td>
<td>Compliant</td>
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<tr>
<td>Regulation 17: Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 27: Protection against infection</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Substantially compliant</td>
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<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
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<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Substantially compliant</td>
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<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
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<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:

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<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<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:
The registered provider shall ensure that (15:1) 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.

This will be ensured by taking the following actions:

• PIC has reviewed the current roster with a view to increase the current baseline to allow for 1:1 staffing for extended periods of time; in order to maximize individual supports for both residents as per their current needs. [Completed]
• The required resources to facilitate the increased supports required have been requested and approved by the Senior Management team for the provision of additional 1:1 supports to meet the needs of both individuals – to be implemented from 2021, following recruitment of suitable staffing.
• Recruitment/ selection procedures will be followed when seeking appropriate staff to support the residents in the designated centre.
• Following the recruitment, induction and training of additional staff, the PIC will ensure the roster in the designated centre is properly planned and maintained; thus ensuring continuity of care and support for both individuals.
• The PIC will thereafter ensure sufficient staffing levels/skill mix as per residents’ needs.

28/02/2021 - timescale for completion.

| Regulation 23: Governance and management | Substantially Compliant |
Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider shall ensure (23(1)(c) that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents’ needs, consistent and effectively monitored.
This will be ensured by:

- Implementing a structured monitoring/over-sight system that satisfies the PIC and the registered provider; to ensure that the service provided is safe, effective and of a high quality; with the persons supported at the fore-front at all times.
- Challenges/ risks will be identified, as per organizational procedures, and will be managed safely and appropriately to ensure minimal impact on the quality and safety of the service provided to the residents.
- Ensuring comprehensive PIC and internal SMT-led audits/service reviews are carried out on a regular basis; and that recommendations are actioned to improve the service provided to both residents.

07/12/2020 - timescale for completion.

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<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:
The registered provider shall provide (34)(1)(a) an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident’s age and the nature of his or her disability.
The registered provider shall ensure (34)(2)(f) 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.
This will be assured as follows:

- The Registered Provider has reviewed the current Complaints procedure; specifically, the complaints log, to include a process of reviewing complaint satisfaction following a complaint being closed [Completed]
- The corresponding accessible complaints procedure is under review by the local self-advocates group.
The PIC will ensure that once this review is complete, and the updated accessible procedure is finalized, that the accessible complaints procedure will be displayed in a prominent location in the service and reviewed with both residents on a regular basis.
- The PIC will ensure effective oversight of local complaints management within the designated centre.
**Regulation 26: Risk management procedures**

Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider shall ensure that (26(2) 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, by ensuring that the following actions are completed:

- A Risk Management Procedure is in place in the organization; and the PIC and SCWs will refresh their knowledge of this procedure and will adhere to it within the service.
- The PIC will review and update current risk assessments within the centre, to ensure all control measures have been outlined in each respective risk assessment and that they are proportional to the risks identified; and will ensure that the residual risk is accurately measured and reflected in the risk scoring.
- The Risk Management escalation process as per procedure will be implemented if required, should risks identified become unmanageable despite all controls in place.
- All identified risks will be risk assessed as per procedure. The PIC will ensure that where risks have been identified; proportional control measures will be put in place; and any adverse impact such measures may have on the residents’ life will be considered.
- Any future identified risks will be managed and reviewed on an ongoing basis as required.
- Risk assessments will be reviewed within appropriate timelines; and will be reviewed along with AIRs reviews, Behavior Support Plans, Individual Plans and relevant protocols.
- The PIC will use the internal files and record keeping review system in place to ensure ongoing review of risk, which is timely and effectively documented.

31/12/2020 - timescale for completion.

| Regulation 27: Protection against infection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The registered provider shall ensure that (27) the residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the
standards for the prevention and control of healthcare associated infections published by the Authority; as follows:

- The PIC will review current protocols and contingency plans to ensure that there are clear guidelines in place for staff to follow if a resident is suspected of having COVID-19 or displays symptoms which could raise an index of suspicion of COVID-19. This protocol/plan will clearly guide staff on necessary precautions to follow to protect themselves and the residents in the centre while trying to minimize any stress or anxiety for both residents.
- The updated protocols will be discussed with all staff at a team meeting to ensure consistency of approach.
- A Preparedness Plan is in place for Caislean, detailing the IPC measures in place within the centre, to prevent an outbreak of COVID-19. A review of the preparedness plan with the PPIMs has been scheduled.

15/12/2020 - timescale for completion.

- The Registered Provider have actioned the gaps noted in the guidance for staff, which could lead to an increased risk in relation to protecting residents and staff from the accidental introduction and onwards transmission of COVID-19.
- The National Clinical Working Group are currently undertaking a review of current guidelines on monitoring staff and resident's temperature, including updating visual guidance on temperature readings; and also to review current guidance/protocols on actions to be taken if staff arrive to work with a high temperature.

31/12/2020 - timescale for completion

<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
<th>Substantially Compliant</th>
</tr>
</thead>
</table>

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

Regulation 28(1): The registered provider shall ensure that effective fire safety management systems are in place. This will be ensured by:

- The PIC has identified the number of doors which require self-closure devices to be installed; and has arranged for the installation of said devices.
- Risk Assessment updated to identify additional controls required/taken as per updated fire safety for community dwellings guidelines.

15/12/2020-timescale for completion
### Regulation 5: Individual assessment and personal plan
- **Substantially Compliant**

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

Regulation 05(6)(d): The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments. This will be completed by:

- The PIC will ensure appropriate oversight of the individual planning process for both residents to ensure it reflects the resident’s needs, while outlining the supports required to maximize the resident’s personal development and ensuring it is developed through a person-centred approach.
- The PIC will ensure that each personal plan is subject to a review and is retained as a live document, taking into account changes in needs or circumstances as they develop. Each review will assess the IP’s effectiveness and will note outcomes achieved; or where outcomes were not achieved, what causal factors resulted in this.
- The PIC will ensure each individual plan details efforts/responses made by support team and strategies implemented in response to altered routines, social and community opportunities and personal goals that are currently not being progressed as a result of living with COVID 19.
- PIC will discuss with staff at team meetings the importance of keeping the plan active and live; and will ensure that there is regular review of progress of personal plans and residents’ goals, to reflect the ongoing commitment of staff to achieve current plan goals and the strategies they have implemented in response to current challenges.

31/12/2020 – Timescale for completion

### Regulation 7: Positive behavioural support
- **Substantially Compliant**

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

Regulation 7 (3): The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the planning process; this will be ensured by:

- The PIC, in conjunction with the Positive Behaviour Specialist, will carry out a timely, thorough review of the current Positive Behaviour Plan in place; which will take into account the current impact of staffing levels, the current escalations and patterns of anxiety identified by staff team and will aim to maximize the use of current therapeutic interventions available to staff and review same if necessary. Staff input will be sought.
throughout all stages.
• Shadowing of resident by Positive Behaviour Support specialist will be carried out as part of the Behaviour Support review process.
• The PIC will ensure Psychiatry review by Consultant Psychiatrist on a regular basis to ensure resident is on the appropriate medication, with clear guidelines on when medication is to be used, as a last resort, when therapeutic interventions are unsuccessful or cannot be implemented. Psychiatry reviews will be focused on reducing the use of medication in so far as possible.
• The service aims to reduce incidents of behavior/ anxiety, by carrying out regular reviews of adverse events/ incidents to identify causes and trends. The service aims to also reduce PRN use by regularly reviewing PRN use with the appropriate multi-disciplinary personnel.

31/12/2020 – Timescale for completion

Regulation 7 (4): The registered provider shall ensure that, where restrictive practice procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. This will be ensured as follows:

• The PIC will review all restrictive practices in the centre; to ensure that their use is proportionate to the risk, the least restrictive measure, and with a view to reducing their use, in accordance with the assessed needs of all individuals.
• Restrictive practices deemed necessary have comprehensive protocols in place; which are reviewed quarterly, using a multi-disciplinary approach. This review will include the number of times the restriction was required in the previous quarter and what efforts will be made to further reduce the restrictions.

31/12/2020 – Timescale for completion
Section 2:

Regulations to be complied with

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

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

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15(1)</td>
<td>The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>28/02/2021</td>
</tr>
<tr>
<td>Regulation 23(1)(c)</td>
<td>The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents’ needs, consistent and effectively monitored.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>07/12/2020</td>
</tr>
<tr>
<td>Regulation 26(2)</td>
<td>The registered provider shall ensure that there</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/12/2020</td>
</tr>
</tbody>
</table>
are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

| Regulation 27 | The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. | Substantially Compliant | Yellow | 31/12/2020 |
| Regulation 28(1) | The registered provider shall ensure that effective fire safety management systems are in place. | Substantially Compliant | Yellow | 15/12/2020 |
| Regulation 34(1)(a) | The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an | Substantially Compliant | Yellow | 24/11/2020 |
appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident’s age and the nature of his or her disability.

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<tr>
<th>Regulation 34(2)(f)</th>
<th>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.</th>
<th>Substantially Compliant</th>
<th>Yellow</th>
<th>24/11/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 05(6)(d)</td>
<td>The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/12/2020</td>
</tr>
<tr>
<td>Regulation 07(3)</td>
<td>The registered provider shall ensure that where required, therapeutic interventions are</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/12/2020</td>
</tr>
</tbody>
</table>
implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.

| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. | Substantially Compliant | Yellow | 31/12/2020 |