Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	An Diadan
Name of provider:	Resilience Healthcare Limited
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	08 July 2020
Centre ID:	OSV-0005667
Fieldwork ID:	MON-0029664

About the designated centre

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

An Diadan is described in the statement of purpose as a high support residential service for adults with intellectual disability and/or autism between 18 and 65 years of age. The service provides life skills, behavioural and social supports and in accordance with the statement of purpose. The service focused on maximising each person's abilities, strengths and independence. Located just outside a village, An Diadan is a four bedroom house for a maximum of four individuals at any one time. Any person who is availing of a full time residential service will have their own individual bedroom. Some bedrooms are set aside for "shared care" whereby residents share a room on a alternate basis. The bedrooms which are identified for "shared care" purposes are shared between a maximum of two people at alternate intervals. Each shared care bedroom is individualised to the persons when they avail of this arrangement. Staffing requirements and supports are informed by a comprehensive assessment of need of each individual. The skill mix of staff is informed by the assessed needs of residents. Where an assessment indicates that an individual requires clinical supports, nursing staff are provided.

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:

Date	Times of Inspection	Inspector	Role
Wednesday 8 July 2020	10:48hrs to 16:30hrs	Carol Maricle	Lead

What residents told us and what inspectors observed

The inspector met with two residents who lived full-time at the centre. On the date of the inspection, a further two residents in receipt of shared care were not at the centre.

The inspector was introduced to and briefly observed one resident. This resident chose to spend considerable time in their bedroom on the day of the inspection and through their body language indicated to the inspector that they wished to be left alone and this was respected. Their bedroom was tastefully decorated and personalised. They had a weekly plan of activities that was specific to them and their interests. It was reported that their family members were in close contact with their staff team and were involved in decisions around their care.

The inspector met a second resident. This resident was getting ready to leave the centre for an outing. While their communication style was not verbal their body language indicated that they were excited about a planned outing. They were dressed appropriately for their age and appeared content in the company of staff. On a second occasion later in the day they were observed spending time both inside and outside their home. They could walk outside and be in the gardens without restriction and this suited how they liked to spend their day. Members of the staff team could articulate clearly this residents likes and dislikes, their preferences for how they wished to spend their day and their learning potential. They also set out how they were supporting the resident in their day-to-day living given the constraints associated with the COVID-19 pandemic.

As both residents communicated in a non-verbal manner the observations of the inspector took into consideration feedback from the staff and management team and documents viewed on the day.

Capacity and capability

This inspection took place during the COVID-19 pandemic and was the fourth inspection of this service. The centre was also renewing their registration at the time of the inspection. This was a risk based inspection carried out on foot of a serious incident that had taken place at the centre in February 2020, following which a provider assurance report was sought from HIQA and received from the provider. This assurance report was around the response of the registered provider to behaviours of concern.

At the previous inspection it was found that non-compliances were identified in the area of complaints, risk management and behavioural support. At this inspection, it was found that not all of these matters had progressed to ensure full compliance with the Regulations. This meant that improvements were still required. Furthermore, it was found that the review of a serious incident in February 2020 was not demonstrative in setting out a formal set of conclusions, learnings and actions arising at a leadership level within the registered provider.

The registered provider put in place management systems to ensure the centre was governed. They had appointed a full-time person in charge to this centre. She also carried responsibilities to a second centre. There was a team leader allocated to this centre to support the person in charge in the discharge of her duties. There was therefore a clear management structure at the centre, as appointed by the registered provider. Staff confirmed their awareness of who was in charge. Both the person in charge and team leader had a detailed knowledge of each resident and were passionate about the rights of the each resident right to live a good life, be connected with their families and places of origin and have a suite of multidisciplinary services around them.

The registered provider had arranged for an annual review of the centre to take place along with two six monthly unannounced inspections conducted in the year prior to this inspection. This demonstrated oversight on their part however the annual review did not set out how it consulted with residents and or their families as part of the review. The six monthly unannounced inspection that took place shortly before this inspection referred to the incident of February 2020 but did not elaborate on learnings from that event. This was significant as this inspection is supposed to prepare a report on the safety and quality of care and support provided at the centre.

From discussions with staff, the team leader and the person in charge and a review of documentation it was clear that they had experienced a challenging number of months earlier this year arising from the difficulties they experienced in responding to the escalated behaviours of a former resident. This resulted in all of the residents being affected by these incidents as they had to on a number of occasions stay in their bedrooms for their own safety (with and or without staff accompanying them) and wait for behaviours to deescalate. During this same time period one serious incident had arisen during which members of an Garda Síochana were called by staff to assist with a resident who was engaging in behaviours that challenged. This situation had now resolved itself as at the time of this inspection a resident had already transferred in a planned manner to a more suitable home that was redesigned for them. A serious incident review report of this incident was not available to this inspector on the date of the inspection but minutes of a review meeting were forwarded shortly following thereafter. This information showed how a formal meeting had taken place shortly after the event and this review included family representatives of the resident involved. However, the inspector did not see reference to formal learnings/conclusions or an action plan compiled following this review. This meant that the inspector could not see that learnings had taken place at a leadership level within the organisation.

During this inspection, the inspector identified that despite a suite of internal audits, documents associated with personal planning and healthcare required better oversight. The inspector identified a number of inconsistencies across both areas upon an initial review of sampled files. The person in charge acknowledged that the time afforded to oversight had been impacted this year due to the escalated behaviours of a former resident and more recently in addressing matters associated with COVID-19 pandemic. While the inspector accepted this was the case, it was of concern that consistent quality across all four files was not maintained.

The person in charge had systems in place to monitor continuing professional development. At the time of this inspection, the majority of staff had completed mandatory training and where this was not the case small gaps were explained and were due to issues such as long term leave. Team meetings were not at the present time being held face to face and there was evidence of key messages being given to staff using other formats. Notwithstanding these positive findings, the person in charge was not conducting formal supervision with the staff team in line with organisational policy and this meant that a formal opportunity for staff to reflect on their work in a one to one format was not provided. This was significant given that the staff team had experience a challenging number of months earlier that year.

At the time of this inspection there was a sufficient level of staffing at the centre and this was confirmed by staff and the management team.

There had been two complaints made in the previous 12 months. The registered provider had provided a complaints procedure for residents which was accessible. The documents viewed did not show that the complainants were satisfied with the outcome, this was of significance as one of the complaints was a complaint made by a family representative following a serious incident that took place in centre in February 2020.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted a complete application for the renewal of the registration of the centre.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge to this centre. She also carried responsibilities to a second centre. She had the necessary experience and management qualification.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that at the time of the inspection the staffing team represented what was set out in the statement of purpose and what was required by the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that staff were appropriately supervised in a formal capacity, in line with their own organisational policy. The majority of the staff team had completed mandatory training at the time of this inspection with a small number of gaps. Staff had attended recent training in subjects relevant to the

COVID-19 pandemic.

Judgment: Not compliant

Regulation 19: Directory of residents

The person in charge maintained a directory of residents and this contained the necessary information.

Judgment: Compliant

Regulation 22: Insurance

The registered provider was insured, as evidenced by documents submitted to HIQA.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre that outlined lines of authority and accountability. The registered provider had arranged for the centre to have two six monthly unannounced inspections in the 12 months prior to this inspection however one such inspection did not contain reference to a serious event that arose at the centre a number of months earlier. The annual review of the centre did not include reference to consultation having been done with the residents and or their families.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider maintained a statement of purpose that was reviewed annually. An amended statement of purpose was submitted shortly following this inspection to HIQA clarifying the arrangements regarding the multidisciplinary team.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had notified the chief inspector of all adverse events that occurred in the 12 months prior to this inspection.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints register did not state whether or not the complainants were satisfied with the resolve of their complaint.

Judgment: Substantially compliant

Quality and safety

This inspection found that the quality and safety of the residents over the previous year had been impacted by events that took place a number of months prior to this inspection regarding behaviour that challenged. At the time of this inspection, this situation was now resolved as a planned and suitable transfer of a resident had taken place. Notwithstanding this positive resolution, there remained an emerging matter of incompatibility again within the home, however actions were now taking place in a prompt fashion to identify the best solution for all residents. Since the previous inspection, the area of positive behavioural support and risk management still required improvement.

This was a residential service that also had a shared care component. This meant that residents living at the centre shared their home with two other residents that availed of shared care. At the time of the inspection, the centre had a capacity of four with one room allocated for shared care purposes. There were two residents living full-time at the centre, two residents in receipt of shared care who alternated between the same room and one vacancy.

The condition of the premises both inside and outside was of a high standard. Each bedroom was tastefully decorated in a personalised manner. The centre resembled a home and there was a nice smell of home cooked food in the afternoon of the inspection. The outside of the premises was of a high standard with plenty of space

for residents to walk freely around without restriction.

This inspection took place during the COVID-19 pandemic and there was evidence of good leadership both nationally within the registered provider and locally by the management team regarding the management of this risk. The registered provider had contingency plans in place and a nominated emergency team to lead out on an organisational response to this risk. The risks associated with COVID-19 were set out in the risk register and the inspector could see that the controls put in place to mitigate against same were carried out in practice. On arrival to the centre, there was a designated station located inside a converted garage to facilitate temperature checks, screening of staff and visitors, hand hygiene and access to personal protective equipment. Staff and visitors then entered the centre from the rear entrance that brought them directly to a utility space and they were asked to wash their hands. Staff were observed adhering to standard infection control precautions, there were adequate hand washing facilities and stocks of personal protective equipment available. Overall, there was a good standard of cleanliness noted throughout the centre. Staff were using personal protective equipment and maintaining physical distancing where appropriate in line with national guidance.

Residents in this centre were afforded opportunities to maintain contact with family members throughout the COVID-19 pandemic. Staff in the centre had appropriately facilitated residents to visit family members since the reduction in restrictions relating to the COVID-19 pandemic.

Despite the above positive findings, there remained a number of areas that required improvement. Regarding the arrangements for personal planning, the inspector found that staff were very familiar with the residents' preferences, their individual likes and dislikes in all aspects of their daily lives. Each resident had an assessment of their needs completed in the previous 12 months. Residents' social care needs and preferences were identified however, the support plans lacked specific detail achievement of the goals set out for the residents. There was poor cross reference of key recommendations from multidisciplinary reports throughout the suite of personal planning documents. There was also a level of inconsistency across all of the personal planning documents as some residents had required documentation (as per the organisation templates) and others did not. This meant that one file may include items such as an absence management plan and money management assessment and another file did not with no clear rationale for same. The contents page on each file differed across all four files and this lent itself to a planning system that was not streamlined and quality assured.

The registered provider had put in place systems to ensure residents had access to healthcare. From reviewing documentation and speaking with staff, it was clear that all four residents had a high level of healthcare requirements and access to allied healthcare was important. Residents were supported to attend the general practitioner, dentist and a suite of other allied healthcare professionals. The inspector found that where assessments had been conducted in areas such as speech and language and occupational therapy these had been developed within the previous 12 to 18 months which was appropriate. The inspector found that some documentation regarding healthcare was poorly audited such as weight

management records that clearly had not been updated in a number of months. The person in charge acknowledged these gaps on the day.

There was a lack of clarity regarding the provision of multidisciplinary services within the organisation. The person in charge informed the inspector that residents did not have a full complement of allied healthcare professionals available within the provider's own multidisciplinary team meaning that residents were thus reliant on public health services. The impact that this had on each resident was not however clearly set out in documentation viewed by this inspector nor risk assessed. Where a resident was in need of psychiatric review there was reportedly a gap in the provision of this service in the relevant geographic region of the health service executive. It was not clear to the inspector why then the resident had not been referred to a contracted service that the provider had in place. This matter was discussed with the head of social care following the inspection who committed to clarifying with the team the suite of contracted services available internally within the provider that all residents could be referred to.

The registered provider had put systems in place to support staff to respond to behaviours that challenge. Staff were trained in the management of acute and potential aggression. From discussions with staff and the management team they conveyed frustration with the level of input from the internal behavioural support team in the year prior to this inspection. This had now been partially been resolved as the inspector was informed that a clinical lead for this area had been appointed internally and a second behavioural therapist was also being appointed. The inspector noted a lack of consistency in the behavioural support plans, as one resident requiring this did not have any plan in place, another had one dated 2018 and two residents had plans recently compiled. Overall, this meant that the staff were operating with training but without clear guidance on how to respond and react to behaviours.

A number of restrictive practices were being used in the centre. The inspector acknowledges that these were primarily used to promote the safety of residents. The decision making records and assessment process seen by the inspector did not demonstrate that these practices were assessed as being the only option available to meet the needs after all other methods were exhausted, were adequately reviewed or if any alternative to the practice had been considered. This was especially the case in the review of practices used by staff when reacting to significant behaviours that challenged in the first quarter of this year.

There were systems in place to keep residents safe and staff reacted and responded to allegations of abuse and peer to peer interactions that were considered threatening or abusive however improvements were identified. Staff reported incidents accordingly and the person in charge took action to ensure that statutory guidance was followed. A significant event had arisen in the centre in February 2020 and the person in charge submitted the required notifications to HIQA and the HSE following this event as they self-reported that a number of the residents were directly impacted by this event.

At the time of this inspection there was an emerging matter of incompatibility at the

centre. Some residents were engaging in peer to peer incidents with each other, as confirmed by staff and as set out in notifications submitted to HIQA. The person in charge confirmed that a meeting had already been scheduled with the necessary professionals and the health service executive to discuss same. Although there were safeguarding plans in place to keep all residents safe the effectiveness of these plans was hampered by lack of a clear and concise plan for each resident. One resident had a safeguarding plan created each time they were involved in an incident which resulted in the resident having multiple plans open at the same time, some of which had been open for a number of months. It was not possible for the inspector to ascertain what the actual plan was to keep a resident safe due to the duplication of multiple plans. The person in charge committed to immediately reviewing this duplication following this inspection.

Where there were safeguarding concerns of a financial matter identified by the provider, steps had been taken to address this however the situation was continuing and despite a safeguarding plan in place legal advice had not yet been obtained. This was significant as the matter had been open a number of years.

A planned discharge had taken place at this centre and this had been conducted in a planned and safe manner resulting in reportedly a better quality of life for a resident. At the time of this inspection there was a proposed transfer being discussed with a family which was reported to be a positive endeavour to transfer a resident closer to their place of origin. This proposed transfer was described as being weeks away from being executed. While the proposed transfer appeared to be based on the wishes of the family and resident the proposals were not set out in writing therefore the inspector could not confirm in writing these plans.

Since the previous inspection, risk management was still found to require improvement as each set of individual risk assessments did not always identify for each resident pertinent hazards relevant to them. From a provider perspective, there was a centre risk register which detailed more generic hazards at the centre.

Fire safety management systems were satisfactory with the required equipment and fire containment systems in place and serviced as required. The premises had a fire alarm panel, emergency lighting, fire containment doors and a number of extinguishers present throughout the home.

Regulation 11: Visits

The registered provider facilitated residents to receive visitors. Given that this inspection took place during the COVID-19 pandemic, the provider was facilitating visits in conjunction with health service executive guidance.

Judgment: Compliant

Regulation 17: Premises

The registered provider ensured that the design and layout of the centre met the aims and objectives of the service and the number and needs of the residents. The premises was of sound construction and kept in a good state of repair externally and internally. The centre was clean and suitably decorated.

Judgment: Compliant

Regulation 20: Information for residents

The inspector viewed the resident guide and it was found to require a small amendment which was was addressed during the inspection thus meeting the requirements of the Regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

Not all residents had an individualised risk assessment conducted of all hazards that were individual to them.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had ensured that they had adopted procedures consistent with guidance and advice from the health service executive and the health protection and surveillance centre in protecting residents from acquiring a healthcare associated infection and COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety management systems were in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each resident had an annual assessment of their needs. Personal planning arrangements were inconsistent across all four files. Recommendations from multidisciplinary professionals were not cross referenced in the personal plans.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had ensured systems were in place for the provision of healthcare for each resident however record charts were found to be inconsistently completed in areas such as weight management. The provision of a multidisciplinary team around the resident was not fully understood.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There was a lack of consistency in the documentation guiding staff in their support of residents that engaged in behaviours that challenged. One resident was without a behavioural support plan.

Judgment: Not compliant

Regulation 8: Protection

The person in charge has ensured that all staff receive appropriate training in adult safeguarding. Where a financial abuse was identified as an ongoing safeguarding concern the registered provider had taken action and a safeguarding plan was in place however the situation remained unresolved for a number of years. Despite safeguarding plans being in place, the effectiveness of same was not reviewed.

Judgment: Substantially 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:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for An Diadan OSV-0005667

Inspection ID: MON-0029664

Date of inspection: 08/07/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge had ensured that staff have access to appropriate training and refresher training and that staff are informed of the act and any regulations and standards made under it. 16(1)(a), (c) All relevant information pertaining to the act and regulations made under it are available to staff. 16(2)(a)(b) & (c) A supervision plan has been developed with agreed times and dates of formal supervision with all staff. Supervision will be provided to staff in line with organisational policy and procedure. All staff (with the exception of 1 on leave for the past month) have now received a formal supervision. There is a supervision plan in place going forward in line with the organizational policy	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider had ensured that: The centre was delivered in line with the SOPAF with clearly defined management structure in the designated Centre	

The registered provider had arranged for the centre to have two six monthly unannounced inspections, November 2019 and June 2020. The inspection in June was completed remotely due to the restriction of Covid-19, it was not possible for the person completing the review to consult with residents as this is done through observations.

The review commenced on the 16th June part 1 (self-assessment) and was concluded on the 26th June. The report was issued to the PIC on the 6th July 2020.

Consultation with family was noted in the review completed in November 2019 and observations of the residents.

The report did not make specific reference to an incident which occurred in June but did refer to the impact of this on other residents and that the resident had been discharged back to their original service.

Your service your say questionnaires were sent out to the families in June 2020 as part of annual review but were not returned, these have been followed up and are expected in service by 21. 08.2020. Going forward the annual review of the centre will be explicit in stating the feedback of residents and other family members.

Significant incidents will be referred to in future quality reviews of the Centre. Consultation and feedback with families will be referenced in the annual quality review.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints register will be adapted to state that the complainants were satisfied with the resolve of the complaint

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All residents had individualized risk assessments conducted of all hazards that were individual to them. On the day of inspection some gaps were noted in relation to two risks

1) Psychological impact of Covid-19 on residents
2) MDT supports

Individual risk assessments will be completed for each resident to include the two points above

All residents had individual risks on file on the day of inspection with the exception of the 2 risks identified above.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The person in charge had ensured that each resident had an annual assessment of their needs and an individual support plan.

Consistent personal planning arrangements will be place in all four files which will include reference for multidisciplinary professionals

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Access to Multidisciplinary support presented with some issues during Covid-19. Resilience employ 2 behavior specialists (1wte), and contract in psychiatric supports from a consultant. Resilience are currently recruiting a full time Speech and Language Therapist and will further build on this in 2020/2021

Until such time that these positions have been filled there are resources to engage multidisciplinary supports when and if required. This has been clarified with the Person in Charge and the Team Lead.

Weights will be completed on all residents in line with organisational policy, unless there is a specific requirement for weights to be taken more frequently. This is specified in the individuals support plan.

The importance of weights has been discussed at the staff meeting. All staff have reread the nutritional policy (including weight management) and signed the policy document.

Staff have been reminded to document any instances where residents chose not to be weighed and alternatives methods of measurements have been introduced in order to monitor changes in weight.

New weight chart has been developed to reflect the introduction of measurements and residents choice.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Three residents at the time of inspection had a behavioural support plan. The resident who had not had the PBSP completed is now in place. Behaviour support plans will be reviewed in consultation with the Behaviour Therapist as and when required.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In relation to regulation 8(2) the PIC has made numerous of attempts to address the issue of a resident not having access to their Disability allowance which included consultation with the HSE safeguarding team, HSE disability services, advocacy services and the Gardaí.

The PIC in consultation with HSE will refer this to the HSE legal team.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	14/08/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2020
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	21/08/2020
Regulation 23(2)(a)	The registered provider, or a person nominated	Not Compliant	Orange	31/12/2020

	by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	14/08/2020
Regulation 34(2)(f)	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	Substantially Compliant	Yellow	14/08/2020

	and whether or not the resident was satisfied.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	04/09/2020
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/09/2020
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.	Not Compliant	Orange	01/09/2020
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Not Compliant	Orange	18/08/2020

	this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	18/08/2020
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	18/08/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/11/2020