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

Issued by the Chief Inspector

Name of designated centre:	Steadfast House Residential Service - Group Home
Name of provider:	Steadfast House Company Limited By Guarantee
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	15 November 2021
Centre ID:	OSV-0001631
Fieldwork ID:	MON-0034842

About the designated centre

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

Steadfast house residential service provides person centred care to five female residents on a full time basis. Residents are supported on a individual basis in line with their assessed needs, wishes and preferences. The centre has a clear and professional management and staffing team in place to oversee the operation of the service. The centre is located within walking distance of a town, and residents can access a range of amenities and activities in the local community. Residents are supported by two staff during the day and one staff overnight. One resident attends day services in a local centre in the community, and day services are provided to three residents in the designated centre, as was their preference. One resident is supported by staff to undertake meaningful day activities. The centre is laid out to meet the individual and collective needs of residents in a homely environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Monday 15 November 2021	07:55hrs to 16:20hrs	Caroline Meehan	Lead

What residents told us and what inspectors observed

This inspection was a risk based inspection and was carried out following receipt of information by the Health Information and Quality Authority (HIQA). In addition, there had been a number of management personnel who had resigned from the service in the days preceding the inspection, including the person in charge, person participating in management and a board member.

The centre was well maintained and each of the residents had their own bedroom. The inspector met with three of the five residents living in the centre and briefly spoke to the two other residents. All of the residents spoken with said they were happy in the centre and felt safe. They also told the inspector who they would speak to if they had any concerns or worries. Residents appeared comfortable with staff and the inspector observed positive and engaging interactions between staff and residents. For example, staff were observed to help a resident with a craft activity, and the staff member supported the resident in telling the inspector about their preparations for Christmas. Staff were also observed to support residents to attend day services and a scheduled appointment.

During the day, the interim chief executive officer (CEO) attended the centre. The CEO had resumed this post in the previous few days. It was evident that the CEO knew the residents well, and that residents spoke to the CEO about their lives, and about changes they would like to see happening.

However, the inspector found that residents were not being provided with safe and effective support, and their rights were not being upheld. There were ongoing safeguarding concerns which had not been identified as such, and consequently not responded to appropriately to mitigate risks. Residents had raised concerns about their safety and wellbeing, and appropriate actions had not been taken by the provider to ensure residents were kept safe. Residents were not provided with appropriate support to manage their emotional and behavioural needs, which exposed residents to a risk of harm. The rights of residents to participate in decisions about their care and support was not upheld, and consequently decisions about residents' future care and support was made in the absence of appropriate and transparent consultation with residents and their representatives. Residents' privacy and dignity was not consistently respected in relation to personal care practices observed.

On arrival to the centre, the inspector met one resident in the dining area, this resident told the inspector they were going to day services and that they enjoyed this activity. The resident appeared comfortable in their environment; however, the inspector observed that the resident was inappropriately dressed, with mismatching footwear and ill-fitting night clothes, and food on their face, arm and nightclothes, all of which compromised their dignity and privacy. The inspector acknowledges that after pointing this out to the staff member, the resident declined help from the staff to change their clothing and footwear. A short time later, when the resident was

being supported to attend to personal care, their lower garment fell. The inspector was not assured, given there was an identified risk relating to the residents' bodily integrity, that appropriate measures were in place to ensure their dignity and privacy was maintained.

There had been some notifications made to HIQA relating to safeguarding concerns in the centre; however, from a review of incidents and subsequently speaking to staff, there were a number of peer to peer incidents which had not been identified as safeguarding concerns and consequently not reported, investigated and followed up appropriately to ensure residents were protected. This was further impacted by a lack of support for residents to manage their behavioural and emotional needs. In addition, actions which had been outlined in the safeguarding incidents reported to HIQA had not been consistently implemented, specifically in relation to a review of behavioural support plans, and behavioural support plans were not in place on the day of inspection. The provider was issued with two urgent actions on the day following the inspection, and had put measures in place by the following day to address the concerns relating to safeguarding and positive behavioural support.

The next two sections will describe the governance and management arrangements in the centre and how these arrangements have impacted on the quality of service the residents received.

Capacity and capability

The provider had not ensured that the service provided was safe, effective and was monitored effectively so as to appropriately respond to residents' changing needs and to emerging risks. There was a lack of oversight by the provider to ensure that residents' were protected, that their needs were being met, and that their rights were being upheld. Similarly practices in the centre relating to medicines management and the response to risks were not ensuring safe and effective support for residents.

As mentioned there had been a number of changes to the management personnel. A new person in charge had commenced in post on the day of the inspection, and there was a new interim CEO appointed in the preceding week, this person had previously held this post, and a position as board member. This was a small service, with two designated centres and a number of day services. The management structure consisted of a person in charge, a CEO (also a person participating in management) and a board of management comprising three members. The CEO met the inspector on the morning of the inspection and informed the inspector that following one member leaving the board, an additional five members had been appointed and were in the process of being inducted into these roles.

On the morning of the inspection and throughout the day, the inspector discussed non-compliance's which were being identified with the interim CEO, this person informed the inspector that in their role as board member they had not been made

aware of most of these concerns up to the day of inspection. For example, some peer to peer safeguarding concerns and behavioural support needs. Furthermore the provider was required by HIQA to complete a provider assurance report in October 2021 in response to information received; however, the new CEO had also not been made aware of the measures outlined in this report.

On the day of inspection, the inspector found a number of concerns and inaccuracies related to the submitted provider assurance report. For example, compatibility concerns were reported as being discussed with the funder; however, there were no compatibility assessments completed; incidents of major concern were to be reported to the Board from August 2021, however, it was not evident that this had taken place specifically relating to ongoing safeguarding concerns.

In addition, the provider assurance report had outlined that a recommendation had been made by a team of professionals that a resident required a specific placement related to a recent diagnosis; however, from a review of correspondence from the team it was not evident that this was wholly the case, and the management team had made arrangements for the resident to be transferred out of the centre in the coming weeks in the absence of a transparent process and may not meet the residents needs. Consequently the inspector found overall the management systems were not ensuring that robust monitoring systems were in place to ensure a safe and effective service for residents, and the oversight of the service required significant improvement.

The inspector found effective arrangements were not in place for staff to raise concerns about the quality and safety of care and support provided to residents. Following a review of incidents records, staff told the inspector that they had raised concerns in relation to some peer to peer safeguarding concerns in the centre, with initial concerns observed in May 2021. However, these incidents had not been reported or investigated as safeguarding concerns and there was no clear plan in place to ensure residents were protected.

Given the level of non-compliance found on inspection, the lack of effective reporting to the board of management, and the instability of the management team, the inspector was not assured that the lines of accountability and responsibility were clearly set out.

There were sufficient staff in the centre to meet the needs of the residents. The provider had employed healthcare assistants and there were two staff on duty during the day and one staff on night duty. Nursing support was provided by the person in charge.

The CEO made the inspector aware that some information was missing from a staff file, and on review there were a number of items that were not available as required by Schedule 2 of the regulations. The provider in response took action on the day of inspection to mitigate the risk.

Notifications had not been made to HIQA related to a number of safeguarding concerns that had occurred in the centre.

Regulation 15: Staffing

There were sufficient staff in the centre with the appropriate skills and experience to meet the needs of the residents. Nursing support was provided by the person in charge. There were two staff on duty during the day and one staff on night duty in a waking capacity.

The provider had not ensured that all information as per Schedule 2 of the regulations was available in staff files. This included a satisfactory history of gaps in employment, two written references, the position held in the designated centre, and the dates the person commenced their role in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems had not ensured the service provided was safe, effective and was robustly monitored on an ongoing basis. There were significant levels of non-compliance found on inspection and there were ongoing risks related to safeguarding, behavioural support, and residents' rights. Assurances which had been provided to HIQA in a provider assurance report were not wholly implemented and in one case not reflective of a resident's needs. Similarly the provider had reported in some safeguarding notifications that behaviour support plans would be reviewed as part of the response to safeguarding incidents; however, these were not in place on the day of inspection.

The provider had not ensured that staff were facilitated to raise concerns about the quality and safety of care and support provided to residents, and there was a lack of response to safeguarding concerns raised by staff.

The lines of accountability and responsibility were not clear. There was an overall lack of effective reporting to the board of management, and a lack of oversight at all levels of management, in order to provide assurances about the quality and safety of care and support provided to residents. Consequently, safeguarding concerns were not dealt with effectively, residents did not have the appropriate behavioural support in place, and residents' rights were not upheld in relation to discharge processes and personal care.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications had not been made to HIQA in relation to some safeguarding incidents in the centre.

Judgment: Not compliant

Quality and safety

While the health and social care needs of residents were provided for, residents had not been appropriately supported with their behavioural and emotional needs. There were ongoing peer to peer safeguarding concerns in the centre, which had not been identified as such, and measures were not in place to ensure all residents were protected. The rights of residents had not been upheld. Risks in the centre had not been managed appropriately following adverse incidents, and significant improvement was required to ensure measures were in place to respond to risks. The procedure for administration of medicines was not in line with national guidance. Information regarding residents' needs was not kept up-to-date.

The inspector followed up on safeguarding notifications which had been made to HIQA in 2021; however, behaviour support plans which were reported as being reviewed, were not in place for the two residents on the day of inspection. Similarly support had not been sought for residents with their behavioural or emotional needs following ongoing safeguarding concerns in the centre. The provider was issued with an urgent action on the day following the inspection, and had put measures in place by the end of that day to address the issue.

There was one restrictive practice in the centre, which had been implemented in recent months following a multidisciplinary team review. This practice had been reviewed by the person in charge approximately three weeks ago and a reduction in the practice was recommended. However, the resident and staff in the centre had not been made aware of this reduction and the restrictive practice was continuing at the level initially agreed.

As mentioned there were ongoing peer to peer safeguarding concerns in the centre. The provider had not ensured that all of the actions outlined in the provider assurance report from October 2021 were implemented in practice, for example, major incidents relating to safeguarding had not been acknowledged as such, and consequently not reported to the relevant authorities or escalated to the board of management. The provider had also identified there were compatibility issues between residents; however, there were no compatibility assessment completed. The person in charge had not ensured alleged safeguarding concerns initially raised by staff, and reported as incidents, had been investigated, and there were no safeguarding measures in place to ensure some of the residents were protected. The provider was issued with an urgent action on the day following the inspection, and had put measures in place by the end of that day to address the issues.

There were also some safeguarding incidents which had occurred a number of months ago, which had not been reported as such. However, the inspector was assured that appropriate measures had been implemented following these incidents.

Risks in the centre were not being managed appropriately. The inspector reviewed individual risks assessments; however, there were a number of risk management plans which were not updated. For example, a fall risk assessment had not been updated in two years, and a risk plan relating to choking had not been updated following review by a speech and language therapist. The person in charge had identified a risk relating to bodily integrity for a resident; however, there were no control measures outlined in this plan. While one staff member described the measures they would take to protect the resident; the inspector observed that this was not consistently implemented in practice, and as described, the privacy and dignity of the resident was not upheld at all times. The inspector reviewed incidents records for 2021; however, it was not evident that appropriate or recorded follow up actions were consistently implemented. In addition to a lack of safeguarding reporting and investigation, in some cases incidents were not evidently discussed at staff meetings as outlined in the follow-up actions.

Up-to-date information was not available in some assessments of need. While it had been identified that this information required review, and staff had marked this in assessment documents, these reviews were not complete on the day of inspection. Personal plans were in place for most identified needs of residents; however, a comprehensive plan relating to one resident's support requirements was not in place. In addition, a plan was in place for a dietary intervention which had since been discontinued by the general practitioner (GP). Residents were supported with their social care needs and accessed a range of amenities in the community. This included going out for meals, visiting their families, shopping, and walks. Residents were also supported to attend day services on a part time basis, as was their preference, and there was sufficient support in the centre should a resident choose to have a day at home instead.

Residents were provided with the appropriate healthcare to meet their needs and healthcare plans were implemented in practice. For example, healthcare monitoring interventions were completed, dietary recommendations were provided for, and residents had attended reviews as needed with the relevant healthcare professionals. Residents could access the support of a GP, a consultant psychiatrist, and allied healthcare professionals such as a speech and language therapist, physiotherapist, and optician.

Residents' rights had were not protected in the centre. The decision to discharge a resident to an alternative facility had been made in the absence of any apparent consultation with the resident themselves and with their representatives. The inspector found the decision to discharge the resident was not made based on transparent criteria, and was not informed by a definitive recommendation by a healthcare professional. The support of an advocacy service had also not been sought for the resident. Similarly a decision had been made recently by the person in charge to keep a resident at home and not attend day service; however, there were no clinical evidence as to why this decision was made. Staff were unaware of

any clinical recommendations as to the reason for the planned discharge of the resident from the centre and their withdrawal from day services, and a staff member told the inspector of the adverse impact a lack of a structured day would have been for the resident.

The resident had returned to day services in the past week, and was reported as enjoying this very much, and this arrangement was being reviewed by the consultant psychiatrist. In the past week, the provider had made the decision not to discharge the resident, and assured the inspector that the appropriate support would be provided for the resident in the centre.

Medicines management practices required improvement. The inspector observed medicines being administered on the morning of the inspection and found administration practices were not in line with guidance. The medication prescription record was not checked prior to giving the medicine to the resident, and the contents of the monitored dosage system was also not checked against the medicine prescription record to ensure accuracy. The inspector discussed with the staff member the details of the medicines they had just administered; however, the staff member was unable to tell the inspector any of the three medicines they had given to the resident. A staff member was also observed to remove tablets from the monitored dosage system with their fingers. Suitable storage was provided for medicines and the key to the medicine was kept secure at all times.

Suitable measures were in place for infection prevention and control. There was adequate personal protective equipment (PPE) provided and staff were observed to wear face masks at all times. Adequate handwashing facilities were available. Staff and visitor temperatures and symptoms were observed to be recorded on arrival to the centre. The centre was clean and a cleaning rota was completed. Staff were observed to attend to the cleaning in the centre during the day, sanitising high touch areas. There were arrangements in place should the residents require to self-isolate, and this measure had been implemented during the year in response to a risk related to COVID-19. Residents had been provided with opportunities to avail of COVID-19 and flu vaccinations.

Regulation 26: Risk management procedures

Suitable arrangements were not in place for the identification and management of risks in the centre. Some risk management plans were not up-to-date, and arrangements were not in place to respond to a risk related to a resident's privacy and dignity.

Adverse incidents involving residents had not been appropriately reported, and the follow up recommendations were not consistently implemented.

Judgment: Not compliant

Regulation 27: Protection against infection

Suitable measures were in place for the prevention and control of infection in line with public health guidelines. These included staff wearing appropriate PPE, monitoring of staff and visitor temperatures, and suitable handwashing facilities. The centre was clean and regular cleaning of the centre was completed. Residents had been supported to avail of vaccination programmes. Arrangements were in place should a resident require to self-isolate.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The procedure for the administration of medicines required significant improvement. The inspector observed that medicines were not checked on the prescription record, and against the monitored dosage system prior to administration, and that medicines were inappropriately handled.

Suitable secure storage was provided for medicines.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

While assessments of need were completed for residents, some of the information in assessments was not up-to-date. A comprehensive plan relating to a resident's identified need was not in place. A dietary plan had not been reviewed following an intervention being discontinued by a GP.

Arrangements were in place to meet the social care needs of the residents, and residents accessed day services and a range of community amenities in line with their stated wishes.

Judgment: Not compliant

Regulation 6: Health care

Residents were appropriately supported with their healthcare needs, and had access

to a range of healthcare professionals in line with their assessed needs. There were regular reviews of residents' needs with healthcare professionals. There was ongoing monitoring of residents' healthcare through interventions in the centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were not provided with the support to manage their behavioural and emotional needs, and appropriate support had not been sought following some peer to peer safeguarding concerns in the centre. Consequently residents were exposed to a continued risk of harm, and staff did not have any guidance on how to manage these behaviours of concern. The provider was issued with an urgent action on the day following the inspection, and had put measures in place by the end of that day to address the issue. Behaviour support plans were not in place for two residents as identified in safeguarding notifications reported to HIQA.

Restrictive procedures were not implemented for the shortest duration necessary, and a restrictive practice had not been reduced following review a number of weeks ago.

Judgment: Not compliant

Regulation 8: Protection

Safeguarding measures were not in place to ensure residents were protected. There was ongoing peer to peer incidents in the centre, which had not been reported or investigated as such. Measures were not in place to mitigate the risks associated with these safeguarding concerns. The provider was issued with an urgent action on the day following the inspection, and had put measures in place by the end of that day to address the issues.

In addition, a number of incidents had not been identified as safeguarding concerns and not reported appropriately.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents rights were not upheld in practices in the centre. A resident and their representative had not participated in a decision relating to their planned discharge

from the centre, and a decision to keep the resident at home from day services. These decisions were made in the absence of any clear clinical recommendations, and staff were unaware of the reasons as to these decisions being made. Advocacy services were not sought for the resident.

Residents privacy and dignity was observed not to be respected in the provision of personal care.

Judgment: Not 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	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Steadfast House Residential Service - Group Home OSV-0001631

Inspection ID: MON-0034842

Date of inspection: 15/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All current staff files have been reviewed to ensure they include all relevant documentation under schedule 2 of HIQA regulations.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Monthly governance schedule put in place between PPIM and PIC. All staff completed safeguarding training and HSE safeguarding audit. Staff also attended a training day on 30/11/2021 on behavior support. A robust communication/collaborative approach quality improvement plan will be put in place completed by the PIC and submitted to the board monthly for comprehensive review. Monthly team meetings to be held with staff and PIC where full overview of residents/incidents/ safe guarding concerns and any potential risk pertaining to any aspect of care and support to be escalated to the board as outlined in health and safety plan.	
Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Registered Provider has reviewed Risk Management Policy and staff have been retrained on risk management procedures within the centre. Meeting will be held with all staff on 06.01.2022 to make all staff aware of their role within risk management and the importance of same. New, more detailed risk management policy will be discussed at length and staff will be given the opportunity to make themselves aware of contents. This Risk management policy will include topics such as roles and responsibilities of staff which will in turn give staff more clarity of purpose.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Registered provider has drawn up a more detailed risk management policy which will be more detailed to ensure all staff within the center have full knowledge and understanding of the process of incident documenting and reporting which will include categories of risk, risk management principles and risk definitions. In house training will be provided by the registered provider around risk management and implementation of new risk management policy on 06.01.2022. All staff completed HSELAND training on 19.11.2021 around safeguarding Vulnerable adults.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: All staff have completed medication competencies again and a full review of medication management has taken place within the center. Residents' medication files have been updated to reflect a more person-centered approach with individual folders. Safe administration of medication training has been organized for all staff on 20.12.2021 with an external trainer. Medication competencies to be completed with all staff on a 3 monthly basis.	

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:
Full review of each residents PCP and risk assessments and management plans to ensure information contained within is relevant and up to date and reflective of residents current care and support needs. Dates have been arranged with Behavioral Consultant for the 8.12.2021 and 15.12.2021 who will review all files and offer support to staff where needed.

Steadfast House CLG Risk and quality sub-committee in conjunction with PIC and staff will carry out a needs self assessment on critical times for extra support to ensure all Residents Dignity and Privacy are being up-held and respected. Recommendation will be actioned immediately to enhance Residents Individual Support Plans. The Provider has now developed "Supporting Autonomy Policy" to support all staff.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All staff attended training on positive behavioral support on 30/11/2021. PBSPs were put in place for residents requiring same. Behavior Specialist reviewed same and meeting was organized for 10/12/2021 to finalize plans and meet with residents concerned.

Review meeting has been organized for 21.12.2021 with PIC and staff concerning restrictive practice in place and minutes of this meeting will be documented and actioned.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff repeated HSE Safeguarding Training and HSE safeguarding tool audit. Individual activity planners have been put in place for residents concerned to mitigate further incidents arising. These planners have been devised with residents themselves with activities of choice to ensure a person-centered approach have been maintained. Key work sessions have been complete with both residents to ensure there is full

transparency at all times and that both residents understand same and respect for each other’s personal space

Safeguarding issues will receive the required seriousness and concerns in the future.
Notifications will be compliant with Regulation.
Appropriate investigations are ongoing on identified historical concerns.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Resident concerned has returned to their day service. Full review of assessed needs to be held on 15/12/2021 with Behavioral Consultant and staff.
Staff and registered provider to ensure full transparency is always held with all residents.
Registered provider has devised two documents- an open discloser document and supporting residents’ autonomy document which have been referenced from HIQAs own document.

National advocacy service has been contacted on 14.12.2021 in relation to each resident so as they understand who they can contact and how to complete a self-enquiry form

All staff to have completed HSEland training on HIQA human rights based approach modules 1-4 by 17.12.2021

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	07/01/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	22/11/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Not Compliant	Orange	22/11/2021

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	13/12/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	20/12/2021
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	Not Compliant	Orange	20/12/2021

	responding to emergencies.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	21/12/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	22/12/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each	Not Compliant	Orange	21/12/2021

	resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	15/12/2021
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.	Not Compliant	Orange	15/12/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is	Not Compliant	Red	16/11/2021

	challenging and to support residents to manage their behaviour.			
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	15/12/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	16/11/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Red	16/11/2021
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and	Not Compliant	Orange	22/12/2021

	support.			
Regulation 09(3)	The registered provider shall ensure that each resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	22/12/2021