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:	Walk A
Name of provider:	Walkinstown Association For People With An Intellectual Disability CLG
Address of centre:	Dublin 12
Type of inspection:	Short Notice Announced
Date of inspection:	25 June 2021
Centre ID:	OSV-0003403
Fieldwork ID:	MON-0032755

About the designated centre

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

Walk A is a community residential service comprising three houses located in South Dublin suburban residential areas. Walk A aspires to support residents with an intellectual disability to achieve a self-determined, socially inclusive life. Walk A provides residential facilities and staff support to residents to empower them to make informed choices in relation to their lives. Each resident is accommodated in a single-occupancy bedroom with kitchen, living room, bathroom and garden areas which are suitable and accessible. The service is registered to accommodate up to 15 adult residents and is resources with social care workers led by a team leader in each house and person in charge of the service overall. The service has access to vehicles and residents have access to local amenities such as shops and cafés.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Friday 25 June 2021	10:30hrs to 17:25hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

The inspector met four of the residents who lived in this designated centre in person, and eight residents provided their opinions, feedback and thoughts on the service through written questionnaires filled prior to the inspection. Residents' experience was also attained through matters raised with the provider through the complaints process and house meetings.

Residents shared with the inspector their views on their home, the staff, what they enjoyed doing with their day, and where they would like things to change. All residents were complimentary of staff and had a good relationship with them. Residents commented that they felt comfortable raising issues or concerns with staff. The inspector observed friendly, patient and kind interactions between residents and staff. Staff evidenced a good knowledge of residents' communication styles and personalities, and supported the residents to communicate their views and their interests to the inspector without speaking on their behalf, and were observant of not speaking about residents in their presence without including them in conversation. One resident commented that whenever they were feeling upset, "staff always put a smile on my face".

In two of the three houses, residents expressed that they did not feel comfortable or safe in their home, primarily due to compatibility issues with their housemates. A resident commented that their home "should be peaceful" and felt like they were "walking on eggshells" in the shared living space, and wanted to have a better quality of life in their home. Another resident commented that they were forced to stay in their bedroom almost all the time and were unable to do any of their own cooking or cleaning or spend any time in the rest of the house. They felt that incidents in the house could be unpredictable and upsetting for them. The provider was in the process of finding a long-term solution to these challenges, and while residents acknowledged this and appreciated that staff were there for them and would take their concerns seriously, they commented that they felt the matter was taking too long to be resolved. One resident had recently been supported to take a week's holiday to spend time away from the house and relax.

Residents in the third house were advised of the inspection the previous day, and one resident met the inspector at the door and welcomed them in, showing them around their home. The house was clean, with a resident proudly explaining how they took the lead on ensuring their house was clean and tidy. Residents also commented on how they were taking precautions to manage risks related to COVID-19. One of the houses had had positive cases of COVID-19 and residents explained how they followed guidance in isolating and sanitising to stay safe until the outbreak was cleared.

Residents were able to personalise and decorated their bedrooms in accordance with their interests and choices. Shared living areas were comfortable and decorated with photographs of the residents with their friends and families. The inspector was

shown examples of where residents wanted changes made to their bedrooms and how staff supported them to decorate and paint them based on their preferences and hobbies.

The residents were supported to stay in contact with friends and family during the social restrictions associated with the pandemic. The designated centre was open to visitors with one resident having a friend over during the inspection, and appropriate checks and precautions were in effect to keep the residents safe. The residents enjoyed gardening, playing video games, and going swimming or to the gym. One resident showed the inspector a newsletter article naming them member of the month in their local gym. Residents were looking forward to social restrictions being eased to allow them to get back to their interests in the community and their work and volunteering projects. The provider was in the process of establishing relationships with workplaces to find suitable employment opportunities for some residents.

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the safety and quality of the service being provided.

Capacity and capability

The inspector found evidence indicating how the service provider had continued to monitor and audit the operation of the designated centre and identify areas for development in light of the assessed needs of residents and the ongoing health emergency. The provider had ensured that staffing resources remained consistent with suitable contingency arrangements to cover absences and a clear line of management and governance. Some gaps were identified in staff training and in the timeliness of notifications to the chief inspector. The provider had commenced a long-term solution to improving the quality and safety of the service for all residents, but at the time of this inspection, the interim strategies had not been effective in providing a positive lived experience for multiple residents.

The designated centre was led by a person in charge, with a team leader assigned to each of the three houses, to manage the day-to-day running of the staff team. The person in charge was knowledgeable of the houses and the residents and routinely spent time in each house to engage with the staff team and the residents. The staff met during the inspection evidenced good familiarity with residents' personalities and communication styles, and positive, engaging, and mutually respectful interactions were observed during the day.

At the time of the inspection, there were a small number of staffing vacancies. These were scheduled for interview the following week, and in the weeks prior to the inspection, the impact of these vacancies on the continuity of staffing for the residents was mitigated, through core staff members working additional shifts, and

the same relief personnel attending when required. In the sample of weeks reviewed, this was sufficient to ensure staff cover without relying on staffing resources from an agency. The rosters clearly identified information such as training days, sick leave, and who was staying over on a sleepover shift.

The provider had completed an annual and six-monthly report on the operation of the service. In these reports it was acknowledged how well the team and the residents had managed risks related to COVID-19 and ensured that residents stayed engaged with health appointments and personal objectives. Areas in need of improvement were also identified, including consistent implementation of actions following adverse incidents, gaps in staff training, and ensuring that documentation was kept current. The provider also acknowledged the challenges arising from resident compatibility in one house in particular, noting the work of the team in responding to safeguarding risk, and an application has been submitted for funding support to seek accommodation more suitable to meeting the needs of residents. At the time of inspection, this business case was not progressing in a time desirable to the provider, and the strategies used in the interim were not having the desired effect of providing a safe and homely space for residents. It also was unclear from this report what plans, or timelines for same, were in progress to address compatibility challenges in a second house of this designated centre. The person in charge advised that possible options to resolve challenges in the second house were largely dependent on successful completion of action in the first house. This annual report was made accessible to residents via a simple language summary, however it was unclear where the writing of the annual report reflected the commentary, suggestions and experiences of the residents themselves in 2020.

For the most part, staff were supported to attend training to stay up to date on skills related to moving and handling, fire safety, safeguarding of vulnerable adults and infection control procedures, However, for some skills assessed as required to effectively support residents in this designated centre, records indicated that that staff had not been provided with training sessions, or were overdue for refresher courses. These gaps included supporting people with autism, safe administration of medication, first aid, and providing a low arousal environment to support behavioural needs.

The residents were provided information on how to make a complaint in the designed centre. The inspector found a highly detailed account of issues raised by residents, in their own words. Minor or verbal complaints were logged and addressed with the same level of detail as more serious matters, to provide a complete picture of what was concerning residents in their home. For each entry, there was a record of how the staff team and the complaints manager had responded to them in a prompt fashion, and taken action to address the matters raised or steps towards a positive outcome. A number of complaints were open at the time of inspection, and would continue to be, until the matter was considered resolved and the resident satisfied with actions or outcomes from same. Residents who had made complaints commented that they felt assured their complaints would be taken seriously.

Regulation 14: Persons in charge

The person in charge worked on a full-time basis and was suitably qualified and experienced for their role.

Judgment: Compliant

Regulation 15: Staffing

The designated centre was staffed to provide a level of support in the house based on residents' assessed needs and level of independence. Current staffing vacancies and absences were consistently filled with relief personnel and overtime shifts to retain continuity of support.

Judgment: Compliant

Regulation 16: Training and staff development

There were a number of gaps in training identified as required to effectively support residents with their assessed needs being provided to staff members, as well as staff who were overdue to attend a refresher session in the required skills.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had insurance in place regarding property and personal injury.

Judgment: Compliant

Regulation 23: Governance and management

There was limited evidence in the annual report of how it incorporated the residents' experiences, suggestions and feedback on the service.

The strategies of the provider to respond to ongoing risk in the centre had not

resulted in the provision of a service which was effectively meeting some residents' assessed needs, and providing a safe environment for other residents to live.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Residents had a written contract with the provider which outlined services provided and fees payable.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose for the designated centre which contained the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

While the provider had notified the chief inspector of adverse incidents occurring in the designated centre, some improvement was required to ensure these were submitted within the times identified in the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider maintained a clear and detailed account of resident complaints, and kept these matters open until a satisfactory resolution was achieved. Complaints were responded to in a timely fashion.

Judgment: Compliant

Quality and safety

Overall, residents were supported to pursue meaningful projects and personal objectives relative to their capacity and interests. Independence and choice was encouraged in how residents arranged their home space and their routine, including activities of daily living and management of medication and finances. Where staff supports were required, there was guidance for staff on how to most appropriately support residents with their needs. The residents in the largest house enjoyed a relaxed, busy and engaging life in a comfortable and homely setting. However, in the other two houses, compatibility and safeguarding concerns resulted in a negative effect on the safe and comfortable lived experience in their home.

The provider had determined a number of years ago that while the staff team had the skills and capacity to support the assessed needs of all residents in the designated centre, some residents would benefit from alternative living arrangements with different or no housemates. The provider had applied for funding to seek a suitable location to achieve this objective. However, until this was resolved, compatibility issues in two of the houses resulted in residents not feeling relaxed in their house or having control of their daily lives. Examples of these included residents being unable to use the shared living spaces and spending more time alone in their room, staff holding onto money for residents who were otherwise independent to reduce risk of it being taken, a buzzer attached to a resident's bedroom to alert to unwanted entry, and incidents of residents not being permitted to enter their house or service vehicle by their peers. The staff had employed strategies to reduce the safeguarding risk through one-to-one staff presence and promoting a low arousal environment. The provider had also arranged breaks away for some residents to spend time in a more relaxed environment, which had a positive and beneficial impact on the resident. However, while the staff team had employed these risk controls, they had not resulted in the residents feeling safe and secure in their home. There had been no downward trend in adverse incidents being notified to the chief inspector of physical, verbal and psychological risks posed due to this incompatibility.

The inspector reviewed examples of personal objectives of a sample of residents. Each resident had multiple goals in progress related to employment opportunities, volunteering in the community, staying in contact with friends or family. Some residents had personal objectives such as maintaining a healthy weight or exercise regime, and developing life skills such as cooking and looking after pets. These personal objectives were discussed at the start of the year between the resident and their key support worker, and the steps towards attaining and maintaining these projects were documented. Where some projects or opportunities had been paused due to the pandemic, they were replaced with objectives which could be progressed effectively, such as residents redecorating their bedrooms, training on horticulture or art classes, or taking the lead on household chores. As community services opened back up and the residents were vaccinated against COVID-19, they were encouraged to recommence activities such as swimming and going to the gym, and meeting up with friends and family with the appropriate precautions in place.

Weekly house meetings took place in which residents set out the meal plan, activities and outings for the week. Residents were supported to prepare healthy meals and snacks in the house, and on Fridays residents enjoyed a takeaway, which was delivered during the inspection.

The living space was clean, suitably designed and in a good state of maintenance. The houses were equipped with sanitising and protective equipment to guard against infection control risk. The provider was in the process of upgrading the fire containment measures with room doors that were rated to contain flame and smoke in the event of a fire. At the time of inspection, approximately half the doors along evacuation compartments were fire rated and the person in charge advised which doors were next for upgrade. The houses had multiple evacuation options and were equipped with emergency lighting to guide a safe exit. The provider had conducted practice evacuation drills in the houses and had achieved low evacuation times. The records of these drills identified where residents may require verbal prompting to exit the building or may not take the most efficient exit route, to provide learning for future reference.

The inspector reviewed medication records for a sample of residents and found that for residents supported by staff, a clear medication administration sheet was maintained which indicted that medications were administered within the times, methods, and doses prescribed. Medication was stored securely with clear labelling of what everything was and to whom it was prescribed. There was an adequate stock of PRN (administered as and when required) medication to ensure ready availability when needed. Some residents had been assessed as having the capacity to self-administer their own medications and an appropriate level of oversight was kept by the staff team to ensure this was followed, through reminders, chats with the residents and ensuring the packs and containers were empty when returned to the pharmacy.

Regulation 11: Visits

The designated centre had returned to accommodating friends and family to visit residents following the restriction due to COVID-19, and followed appropriate precautionary measures to keep people safe.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported to individualise and decorate their personal space in line with their wishes and preferences. Where residents required staff support with managing money, there were appropriate oversight arrangements.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to pursue meaningful opportunities in employment, recreation, relationship and personal development objectives with the support of their keyworker.

Judgment: Compliant

Regulation 26: Risk management procedures

Some improvement was identified by the provider regarding reviews, actions and learning following adverse incidents in the designated centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The designated centre was clean and suitably equipped to control risks related to infection control.

Judgment: Compliant

Regulation 28: Fire precautions

The provider was in the process of upgrading doors along fire compartments to provide suitable containment.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Staff were provided guidance on the correct dose, time, and protocols related to residents' prescribed medication. Staff retained an appropriate level of oversight and

checks to be assured that residents who self-administered their own medication did so consistently.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff were provided sufficient guidance on supporting residents whose behaviour in response to stress presented a risk to themselves or others. Provision of a low arousal environment to support residents was promoted over the use of restrictive practices.

Judgment: Compliant

Regulation 8: Protection

In two of the three houses of the designated centre, residents did not feel safe in their home and were unhappy and uncomfortable in their current living arrangements. The strategies and staff interventions in place to protect residents from harm or distress had not resulted in residents being safeguarded from incidents of verbal, psychological and physical abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents expressed that due to not feeling safe or comfortable in their home, they could not cook or clean or use shared living spaces in their daily lives and spent much of their time in their bedroom.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Walk A OSV-0003403

Inspection ID: MON-0032755

Date of inspection: 25/06/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. By August 31st 2021 the Learning and Development Officer, PIC, HR Officer will have met and reviewed the training status of all staff in DCA. 2. A training schedule that addresses the gaps identified in that analysis will be developed by September 17th 2021. 3. All identified outstanding training will be completed by November 30th 2021. 4. By December 16th 2021 the PIC, Learning and Development Officer and HR Officer will have established a schedule of quarterly reviews on the status of training in DCA.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. In the bi annual internal inspection reports in quarter 3 2021 and in the annual review for 2021 which is due by February 12th 2022 evidence of the resident's experiences, suggestions and feedback on services is made explicitly clear using the template of page 5 HIQA June 2021 inspection report – "what residents told us and what was observed" 2. Assessed needs response	

a) By September 30th 2021 The PIC, Team Leader, Healthcare Co-Ordinator and Assistant Psychologist have a schedule of clinical and healthcare reviews for an identified resident at which local relevant data collation and analysis informs treatment plans and support interventions.

b) By 15th September 2021 a revised healthcare management plan supporting better understanding, monitoring and response on two specific elements of healthcare is collaboratively developed by the PIC, Team Leader, Healthcare Co-ordinator, Assistant Psychologist and relevant health professional.

c) For the remainder of 2021 the PIC and Assistant Psychologist ensures the outcome of that healthcare plan is reviewed at monthly Clinical review meetings

d) By September 30th 2021 the Assistant Psychologist has completed an interoception assessment

e) By October 30th 2021 the findings from that assessment informs supports and interventions on pain management and sensory processing abilities

f) By September 17th 2021 the person in charge and the team leader have reviewed the program of support and engagement for each of the people living in two of the houses where issues of safeguarding have been identified. This review has resulted in the existence of a support response/schedule which enhances the residents range of engagement opportunities in activities of meaning and preference, optimizes the quality of shared time together for residents, allows for necessary time apart and enhances coping and resilience capacity.

3. Safe environment

a) Increased levels of staffing in one of the houses is to be extended until the end of quarter 4 2021

b) A review of the arrangement of for supporting a part time residency which involves the primary stakeholders is to be completed by the PIC before 31ST October 2021 and recommendations on alternatives presented to the senior management team

c) A schedule of enhanced holiday opportunities is created by the PIC by September 15th 2021 which allows residents in two houses more opportunity for quality time away from housemates and environments where tension and wellbeing are currently cause for concern

d) By August 31st 2021 the Assistant Psychologist has a schedule of monthly 1:1 support sessions with identified residents in which coping strategies are discussed and reviewed with the resident. The effectiveness of those interventions are reviewed under the professional guidance with the Clinical Psychology Consultant to the organization on a monthly basis as part of the clinical supervision framework and the PIC is informed of any aspect relevant to associated social care practice.

e) At September 17th there has been a meeting with Day Services and the PIC to identify a timeframe for the potential increase from three day supports and return to five day supports for two residents.

f) By July 31st 2021 Senior management Team will escalate request for meaningful engagement with funders on the submitted business case on individualization of services to the National Office.

g) By 31st July 2021 the PIC and Senior Management Team will have requested and met with the CHO Safeguarding Office, provided updates on the status of the safeguarding plans and engaged with that Office in an agreed collaborative pathway to resolution

h) The process of engagement with the family of one of the residents is recommenced by the Senior Management Team by July 31st. In that process the longer term alternative model of support, the interim possibilities in the model of support and the potential implications on the sustainability of support in the absence of appropriate alternatives are identified.

i) The process of engagement with the family of another resident is recommenced by the PIC and Senior Management by August 31st 2021 and the potential for involvement of legal advisors, ombudsman, confidential recipient, political representation, advocacy and other sources is explored in that process.

j) Engagement with families, funders, Safeguarding Teams informs the SMT engagement process with the Approved Housing Body partner of choice. By September 30th 2021 there is clarity on the need/potential for an interim model of support plan with access to private rental accommodation and on the need/potential for the longer term model of support with access to AHB accommodation.

k) A new Team Co-ordinator / PIC is recruited by the organization by August 31st 2021 to co-ordinate the transition to new model of service

l) In the event of moving to an interim private rental model a property that meets identified specification requirements is sought and secured by PIC / AHB by the beginning of quarter 1 2022.

m) An application for registration as a new designated centre is made by the PIC to HIQA in quarter 1 2022

n) The optimum Local Authority Housing Area is agreed with one of the residents and family by October 31st 2021.

o) Application for inclusion on that Local Authority Housing list is submitted by the person with support of the PIC by 30 November 2021

p) In January 2022 the Approved Housing Body of Choice partner engages with the Local Authority in that area and seeks approval from them for application for Capital Assistance Scheme funding to the Dept of Housing

q) Once approved the Approved Housing Body commence property search based on previously identified specification

r) Following funding approval, property find and new staffing recruitment senior management team ensure the application to HIQA for registration of that property as a Designated Centre and the formal registration of the new PIC.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC will make more effective the submission of notifications by the electronic calendarizing of the notification return dates and electronic reminders will serve as a safeguard to timely returns

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The PIC will confirm with the Director of Residential Services by July 31st 2021 the completion of actions and reviews and learning from Incidents as identified in the Quarter 1 / Quarter 2 Internal Bi Annual report.
2. The PIC will review the electronic IRF system on a quarterly basis and report in one to one meetings on their status to her line manager

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The PIC will submit in October 2021 as part of the 2022 budget planning process proposals for further fire upgrade works and costs
2. Actioning those works subject to approval commences is February 2022

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. By September 17th 2021 the person in charge and the team leader have reviewed the program of support and engagement for each of the people living in two of the houses where issues of safeguarding have been identified. This review has resulted in the existence of a support response/schedule which enhances the residents range of engagement opportunities in activities of meaning and preference, optimizes the quality of shared time together for residents, allows for necessary time apart and enhances coping and resilience capacity.

2. Increased levels of staffing in one of the houses is to be extended until the end of quarter 4 2021

3. A review of the arrangement of for supporting a part time residency which involves the primary stakeholders is to be completed by the PIC before 31ST October 2021 and recommendations on alternatives presented to the senior management team

4. A schedule of enhanced holiday opportunities is created by the PIC by September 15th 2021 which allows residents in two houses more opportunity for quality time away from housemates and environments where tension and wellbeing are currently cause for concern

5. By August 31st 2021 the Assistant Psychologist has a schedule of monthly 1:1 support sessions with identified residents in which coping strategies are discussed and reviewed with the resident. The effectiveness of those interventions are reviewed under the professional guidance with the Clinical Psychology Consultant to the organization on a monthly basis as part of the clinical supervision framework and the PIC is informed of any aspect relevant to associated social care practice.

6. At September 17th there has been a meeting with Day Services and the PIC to identify a timeframe for the potential increase from three day supports and return to five day supports for two residents.

7. By July 31st 2021 Senior management Team will escalate request for meaningful engagement with funders on the submitted business case on individualization of services to the National Office.

8. By 31st July 2021 the PIC and Senior Management Team will have requested and met with the CHO Safeguarding Office, provided updates on the status of the safeguarding plans and engaged with that Office in an agreed collaborative pathway to resolution

9. The process of engagement with the family of one of the residents is recommenced by the Senior Management Team by July 31st. In that process the longer term alternative model of support, the interim possibilities in the model of support and the potential

implications on the sustainability of support in the absence of appropriate alternatives are identified.

10. The process of engagement with the family of another resident is recommenced by the PIC and Senior Management by August 31st 2021 and the potential for involvement of legal advisors, ombudsman, confidential recipient, political representation, advocacy and other sources is explored in that process.

11. Engagement with families, funders, Safeguarding Teams informs the SMT engagement process with the Approved Housing Body partner of choice. By September 30th 2021 there is clarity on the need/potential for an interim model of support plan with access to private rental accommodation and on the need/potential for the longer term model of support with access to AHB accommodation.

12. A new Team Co-ordinator / PIC is recruited by the organization by August 31st 2021 to co-ordinate the transition to new model of service

13. In the event of moving to an interim private rental model a property that meets identified specification requirements is sought and secured by PIC / AHB by the beginning of quarter 1 2022.

14. An application for registration as a new designated centre is made by the PIC to HIQA in quarter 1 2022

15. The optimum Local Authority Housing Area is agreed with one of the residents and family by October 31st 2021.

16. Application for inclusion on that Local Authority Housing list is submitted by the person with support of the PIC by 30 November 2021

17. In January 2022 the Approved Housing Body of Choice partner engages with the Local Authority in that area and seeks approval from them for application for Capital Assistance Scheme funding to the Dept of Housing

18. Once approved the Approved Housing Body commence property search based on previously identified specification

19. Following funding approval, property find and new staffing recruitment senior management team ensure the application to HIQA for registration of that property as a Designated Centre and the formal registration of the new PIC.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

1. By September 17th 2021 the person in charge and the team leader have reviewed the program of support and engagement for each of the people living in two of the houses where issues of safeguarding have been identified. This review has resulted in the existence of a support response/schedule which enhances the residents range of engagement opportunities in activities of meaning and preference, optimizes the quality of shared time together for residents, allows for necessary time apart and enhances coping and resilience capacity

2. In August 2021 an environmental analysis of the two houses is conducted to identify opportunity for optimizing shared and private space.

3. Access to evening use of day services facilities as a means of providing more opportunity to cook etc either in that location or at home while housemates are in that day service space will be considered and actions proposed by the PIC in consulation with residents by August 31st 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	16/12/2021
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.	Substantially Compliant	Yellow	31/03/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide	Substantially Compliant	Yellow	31/03/2022

	for consultation with residents and their representatives.			
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	31/07/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	28/02/2022
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.	Substantially Compliant	Yellow	31/07/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in	Not Compliant	Orange	17/09/2021

	accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			