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:	Sligo Semi Independent Accommodation
Name of provider:	RehabCare
Address of centre:	Sligo
Type of inspection:	Short Notice Announced
Date of inspection:	19 November 2020
Centre ID:	OSV-0004442
Fieldwork ID:	MON-0030531

About the designated centre

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

Sligo Semi-Independent Accommodation provides residential support to male and female adults with an intellectual disability. The centre provides support to residents based on the social care model, and identifies themselves as a low support service for residents to assist them to maintain and develop their independence in all aspects of daily living. The centre is located in a residential area on the outskirts of Sligo town, but close to local amenities such as shops and leisure facilities. The centre is also a short walk or accessible by public transport to further facilities and amenities in the town centre. The centre comprises of two houses in close proximity to each other. Residents have varied levels of independence and support needs and staff are available to support the individual needs of each resident. One house provides accommodation for three residents. Residents have access to a communal sitting room and kitchen/dining room as well as two bathrooms with shower facilities in each. The house also contains a staff office which caters for the administrative needs of both houses within the centre. The second house provides accommodation for four residents. Residents have access to a communal sitting room and kitchen/dining room along with a bathroom with a shower facility and an additional downstairs toilet. Both houses have rear gardens, which are accessible to residents at the centre. Residents are assisted by a staff team comprising of a person in charge, team leader and two community support workers. Staffing arrangements are provided from 09.00 to 22.00hrs Monday to Friday and between 12.00 to 18.00hrs on a Saturday and Sunday. Support to residents is provided in line with individuals' assessed needs. There are no staff overnight in either of the locations in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 19 November 2020	10:30hrs to 17:00hrs	Thelma O'Neill	Lead

What residents told us and what inspectors observed

The designated centre consisted of two houses which were located nearby each other in a housing estate in Sligo. On the day of inspection, there were four residents in the centre, two residents in each house. Three residents had chosen to go home to their families during the COVID-19 public health crisis, and had not yet returned to the centre.

Due to the COVID-19 pandemic, the inspector spent time in one house only, and met with the two residents from that house. The inspector met with the person in charge and the acting person participating in the management of the centre during the inspection. The inspector adhered to public health guidance in relation to face masks and physical distancing. The inspector met with one resident on arrival at the centre. The resident showed the inspector two lovely pieces of pottery that they had made themselves. The resident spoke about the activities in the house that they were involved in during COVID-19 and said that at times they were bored due to the public health restrictions, but were supported by staff to be active. This resident was retired and told the inspector that they had recently had surgery on their foot and they were delighted to have their independence back again and to be able to go out for walks with their dog in the locality. The resident also told the inspector they were in the process of moving their bedroom upstairs.

The second resident was working in a local shop daily and was kept busy during the pandemic. The managers told the inspectors that the residents living in the other house had similar experiences and one resident that was at home for a couple of months during the summer had returned a few weeks ago to the centre. The team leader was providing outreach support to the residents at home a couple of times a week. There was evidence of consultation with the residents' about their care and support needs, and staff had regular residents meetings and the provider audit had identified that residents were happy in the centre.

Capacity and capability

This inspection was completed to review compliance with the regulations and to review the provider's continued response to previous inspections' actions with the aim of removing a restrictive condition on the centre's registration. This centre has been on a regulatory plan for the last fourteen months and has had four inspections completed during this time. On the last two inspections the inspector found the provider had made positive improvements towards compliance in the centre, however, on this inspection, the provider did not demonstrate it had the capacity and capability to maintain the quality improvement initiatives previously implemented, as all of the non-compliance's identified on this inspection

had previously been identified on other inspections over the past last fourteen months.

Following the last inspection, the provider had given the Health Information and Quality Authority (HIQA) assurances in their compliance plan that they would address the actions required to bring the centre back into compliance; however, they were not addressed. For example; three of the four actions identified on the inspection in July 2020 were not complete. These included, training and staff development, governance and management and risk management. Furthermore, previous improvements had regressed from compliant to non-complaint again on this inspection.

The inspector found that the provider had not ensured each residents' assessment of need and support plan was up to-date, and that safeguarding plans were in place when needed. In addition, residents' rights were not promoted and restrictive practices placed on a resident's civil liberty was not appropriately assessed, reviewed and managed. Furthermore, the person in charge told the inspector, there were no restrictive practices in use in the centre. However, the inspector saw restrictive practices recorded in a resident's risk assessment that were in use in the centre and they were not notified to the Health Information and Quality Authority as required by the regulations.

The person in charge of this centre was responsible for the management of three designated centres. While she had the qualifications and experience to manage the centre, she did not demonstrate effective governance or operational management and administration of the centre. For example, the team leader and person in charge had arranged regular support and supervision meetings to ensure the operational management of the centre was robust, however, on review, these supervision meetings did not result in good governance of the centre, as the actions identified had not been acted upon and in some cases, the ongoing care and support issues in the centre had not been identified as areas of concern.

Following previous inspections of the centre, the provider had implemented an online tracking system to identify and monitor previous regulatory actions for each centre nationally. This tracker form was updated by the person in charge, persons participating in the management of the service, and reviewed by the quality and governance directorate nationally. In addition, the tracker was used to provide assurance to the board of management on a monthly basis. However, on review, the compliance tracker had not identified that three of the four actions from the last inspection in July were not complete. These included actions in risk management, staff training, and governance and management. The provider had also completed two six monthly external audits in the centre, the most recent being on the on the 8 October 2020 and twenty actions were identified, including staff training and development, risk management and governance and management arrangements; however these actions were not yet complete.

The provider had also completed an annual review of the quality and safety of care in the service in June 2020, and the actions identified in this audit were not completed. For example: the provider had identified issues regarding outstanding

training for staff and the need to update staff training records, individual risk assessments, and safeguarding plans. However, none of these actions were complete.

On previous inspections there were inadequate staffing resources in the centre, however, the provider had implemented staff support shared between the two houses from 09.00 to 22.00hrs Monday to Friday and from 10.00am to 18.00hrs on Saturday and 12.00hrs to 16.00hrs on Sunday. On review, the staffing arrangements in the centre included a team leader and two social care workers. However, there there were inconsistencies in the staffing rosters with regard to the hours staff were working in the centre.

The person in charge told the inspector that when the centre was quite in the evenings or when some residents went home due to COVID-19 staff support was not needed, and staff would finish early. However, there was no staffing risk assessment completed to ensure that the remaining residents care and support needs were being met, as staff were not readily available to residents if needed. For example, over a number of months the staff rosters showed staff finished duty anytime between 19.00 to 22.00hrs in the evenings, and occasionally there was no morning or afternoon staff cover recorded on the staff roster.

The inspector found that the staffing support available to one resident was not meeting their needs. For example, they were assessed as requiring staff supervision later in the evening to support them with self-medication. However, due to staff finishing work at 10pm at night, a curfew was placed on this resident to be home by 10pm before the staff went off duty to ensure they were home safe and they had taken their medication. This measure demonstrated that the service was not person centered and the resident had to respond to the service, rather than the service responding to the individual needs of the resident.

All staff had been provided with mandatory training in order to support residents in the centre. This included fire safety, manual handling, and positive behaviour support training. The provider had arranged for all staff training to be available on-line due to the COVID- 19 pandemic. However, on the day of the inspection the person in charge had not completed online training for safe moving and handling of residents and she was completing it during the inspection. In addition, a review of staff training records found that a staff member who commenced work in April this year, had outstanding training in safeguarding of vulnerable adults, infection control, food safety and epilepsy management. In addition, the training records were incomplete as all staff training records were not readily available to view, and there was no date on some of the training certificates to identify when staff had completed the training. Staff training was an action on each of the last four inspections in the centre, but had not been adequately addressed to-date.

As part of the application to register this centre under the RehabCare Group, the provider had submitted a statement of purpose for this centre, which outlined the services and facilities provided and the staffing and governance arrangements in the centre. On review of the statement of purpose, the inspector found the staffing

support arrangements identified in the centre were not accurate, as it stated that there was no staff on duty on Sundays, public holidays and it referred to previous staffing support provided by another designated centre next door that was no longer in use.

Overall the inspector found that while the provider had identified most of the issues themselves, the actions taken to date had not been timely and had not assured residents were adequately supported to meet their care and support needs and that all residents rights were respected.

Regulation 14: Persons in charge

The person in charge was responsible for management of three designated centres. While she had the qualifications and experience to manage the centre she did not demonstrate effective governance, or operational management and administration of the centre.

Judgment: Substantially compliant

Regulation 15: Staffing

The inspector found that while the provider had put additional resources into the centre in recent months. The staff arrangements in the centre were inconsistent, and there was no clear system to show how the staffing hours allocated in the centre were effective in meeting the care and support needs of the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff working in the centre did not have up to date training in safeguarding, safe moving and handling, Positive behaviour support, epilepsy management, food safety. Staff training was an action from the last four inspections and was not addressed.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place in the designated centre did not ensure the service provided was safe, appropriate to residents needs, consistent or effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had developed a statement of purpose, which outlined the services and facilities provided at the centre and staffing and governance arrangements in place. On review of the Statement of purpose the inspector found it did not clearly outline the staffing support arrangements in the centre, as it stated that there was no staff on duty on Sundays, public holidays and it referred to previous staffing support provided by another designated centre next door that was no longer in place.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge did not identify restrictive practices in place in the centre, as restrictive, and did not report the restrictions to the chief inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had an effective complaints procedure in place and it was clear that complaints were effectively logged and investigated in line with the organisations complaints policy and procedure.

Judgment: Compliant

Quality and safety

The inspector found that improvements were required in quality and safety of care provided to the residents in this centre. The residents told the inspector they were

happy in the centre, However, the inspector found documentary evidence that the provider was not ensuring the residents had up to-date assessments of needs or support plans in place, and individual risks and safeguarding concerns were not appropriately identified, recorded, and monitored in the centre.

While this centre was identified as a semi-independent service, some residents' risk assessments identified they required more support than what was being provided in the centre, for example; in relation to medication management, fire safety, and protection. Furthermore, due to the inadequate assessment of need and control measures, restrictive practices were put in place that were not rights assessed or reviewed. Consequently, it was not clear if the services was sufficiently meeting the residents needs, as the resident's freedom to exercise choice and control in their daily life was restricted. For example, when one resident was out socialising at night they were required to be back in the centre before staff went off duty at 10pm. Furthermore, these restrictions were not identified as restrictive measures and were not notified the Health Information and Quality Authority as required by the regulations.

The inspector found evidence that this resident who was quite independent, was vulnerable to financial abuse, (external to the centre). The person in charge acknowledged to the inspector that this was a ongoing safeguarding risk, but she had not identified the need to put a safeguarding plan in place in the centre, and did not ensure all staff had training in protection, so that they would be aware of the actions to take in the event of an incident being reported in the centre.

Furthermore, there were four incidents in the unstaffed house where the fire alarm was activated in recent months, when the resident was cooking in the kitchen. In addition, this resident also had refused to leave the house during a number of fire drills in the centre. The person in charge told the inspector that she was assured the resident had capacity to understand the potential fire risks and that she had addressed the risks with the resident. However, these risks were rated low on the centre risk register for both cooking and fire evacuation risks, despite several incidents occurring in the centre and the fact that there was no staff support overnight if a fire occurred in the centre.

The inspector reviewed two residents support files (one from each house) and found that while there was information regarding the residents care and support needs, the information recorded did not reflect the residents' current care and support needs. One resident's assessments of need had not been updated for more than a year and their support plans were not clear, as to their support requirements in managing specific health and social care needs. For example; one file did not contain details of referrals by members of the multidisciplinary team for support required around a social issue.

The inspector reviewed a number of individual risk assessments that had recently been reviewed by the local management team. In one example, a residents' risk assessments was not clear, as to what was a real or potential risk for this residents.One person's risk assessment identified that they were at risk when there was no staff present in the centre; to food poisoning, sexual exploitation

abuse, and assault; however, there was no evidence in their assessments of need or support plans that this resident was at risk from these issues, or that any of any of these issues had occurred to them. In a different residents risk assessment the resident was identified as requiring staff support from another designated centre at the weekends for medication support, however, despite the risk assessment being recently re-assessed, the person in charge confirmed the resident no longer needed this support, as there was staff available in the centre at the weekends and the risk assessment was not up to date.

Alternatively, actual risks where a resident had a history of consuming too much alcohol on occasions when they went out socially, which staff had identified them at risk of missing their medication at night, which could impact on their mental health did not have a clear plan in place to ensure the resident was supported to self- medicate at night. The controlled response was to place several rights restrictions on them. This included limiting the type, and number of alcoholic drinks the resident could have on a night out to three beers, and not to drink specific drinks, and that they were to be home by 10pm at night. The inspector observed in the residents risk assessment that staff recorded the resident frequently did not adhere to these control measures. However, there was no evidence staff escalated the residents failure to return home before they finished duty as an incident, despite the staff identifying the residents vulnerability. Consequently, staff had not ensured the resident had taken their medication as required until a staff member came back on duty the next day.

The provider had systems in place in relation to infection prevention and control (IPC) including; a specific COVID-19 folder which contained information relating to the virus, personal protective equipment (PPE), staff training in IPC and posters regarding IPC measures such as hand washing. The person in charge had awareness of measures required to minimise the risks of contracting COVID-19 including use of face coverings when out in public, use of hand gel and physical distancing.

The inspector reviewed the management of complaints in the centre and found that they were all reported and investigated in line with the organisational policy and procedures. there were no open complaints in the centre and the manager was clear in the management of complaints.

Regulation 26: Risk management procedures

The management of organisational and individual risks in the centre was not effective; in relation to the management of safeguarding risks, alcohol consumption, fire safety and self medicating. Furthermore, the centre's risk register did not clearly identify all of the risks at the centre, and where required had not been escalated by the person in charge in line with the provider's risk management policy.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had systems in place for infection prevention and control; including availability of PPE, staff training, and a COVID-19 response plan in the event of a outbreak in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge did not ensure each resident had a comprehensive assessment of need in place, which reflected their changes in need and circumstances on at least an annual basis. Furthermore, residents personal plans were not reviewed, and multi-disciplinary support recorded in their plans. There was also no record that residents' concerns were effectively considered in the plans, and the effectiveness of the residents' plans was appropriately reviewed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The person in charge had not identified there were restrictive practices in use in the centre. There was no rights restriction assessment or review completed and the restriction was not referred to the restrictive rights committee or reported to HIQA as required.

Judgment: Substantially compliant

Regulation 8: Protection

The person in charge did not recognise a safeguarding risk in the centre where a resident was at risk of financial abuse in the community. The resident did not have a safeguarding plan in place, to ensure all staff were aware how to protect the resident if the issue arose while the resident was residing in the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

A resident's freedom to exercise choice and control in their daily life was negatively impacted when a curfew was placed on them to return to the centre at 10pm at night, to ensure staff were available to supervise them with their night medication. In addition, staff had placed a limit on the number and type of alcohol the resident was allowed to consume when on social outings. Despite the resident's objections to the control measures, these restrictions were not reviewed with the informed consent of the resident.

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	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sligo Semi Independent Accommodation OSV-0004442

Inspection ID: MON-0030531

Date of inspection: 19/11/2020

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 14: Persons in charge	Substantially Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:

• The provider has implemented a plan to ensure effective governance, administration and operational management of the service to include an enhanced system of support and oversight. This plan will be achieved on by the 19th of February 2021 and will be reviewed on a monthly basis by the ISM thereafter to ensure ongoing compliance in the service.

• The Integrated Service Manager (PPIM) has been assigned to be on site 2 days per week until the end of February 2021. As part of the plan the ISM will meet with the PIC on weekly basis to track progress and to support the PIC in fulfilling duties in a structured manner, ensuring management of priorities and systems & processes in the service.

• The PIC will demonstrate their presence on site on a weekly basis and this will include planned protected time for administration and ensuring PIC oversight and governance responsibilities can be achieved on within the designated centre.

• Additional support will also be provided by internal support functions, Quality and Governance will ensure regular compliance checks are carried out in this service for the next 6 months to ensure ongoing compliance with the regulations. Training and Development will work with the Person in Charge to ensure all staff have the required training and within the required timeframes.

• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• Commencing week beginning 30/11/2020 there will be a planned and actual worked rota available in the service, the PIC will sign off on the Worked Rota at the end of each month.
• The PIC will conduct a staffing needs assessment to ensure appropriate staffing levels to meet the assessed care and support needs of residents and to ensure maintenance of appropriate staffing levels on an ongoing basis. This will be completed by 21/01/2021.
• The allocation of staff hours in the service can vary from week to week depending on activities, visits to home etc. The Staffing Risk Assessment for the service will be reviewed and updated to reflect these variables and this will be used to inform the allocation of staff hours on the Rota. This will ensure that there is consistency of staffing and that the staffing is allocated to ensure that staffing resources are responsive to and led by resident's needs. This will be completed by the 21/01/2021.
• The allocation of staffing resources will also be informed by the review of each residents Individual Assessment of Need, Support Plans and Individual Risk Assessment to ensure that their support requirements are being provided for. This will be completed by 15/01/2021.
• The PIC will ensure in completing the Residential Services Monthly Audit that staffing is reviewed and that it is adequate in responding to resident's care and support needs. Staffing will be reviewed on an ongoing basis to ensure that it is responsive to emerging needs. This will be completed by 18/12/2020 and will be ongoing each month. A copy of this Audit will be made available to the ROO and Director of Care at the end of each month.
All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• All outstanding staff training will be completed by the 18/12/2020.

• Going forward the provider will ensure all new staff will complete Mandatory Training including COVID specific training before they commence working in the service. This is effective from the 19/11/2020.

• A staff training template will be put in place locally to record and monitor all training completed. This will ensure that at all times there will be an accurate record of training in the service. This will be completed by the 15/01/2021.
• The PIC will audit the staff training records on a monthly basis to ensure the timely completion of all training including refresher training. This will be completed by 18/12/2020 and ongoing on a monthly basis.
• All staff will engage in a suite of refresher training & reflective practice to build capability and to ensure consistent messaging in the service in response to resident needs and in line with organisational policy and procedures. This will be completed by 26/03/2021.

Training will include: -
- Person Centred Planning & Best Practice in Keyworking
- Risk Assessment
- Restrictive Practices
- Positive Behaviour Support Planning
- Safeguarding of Vulnerable Adults
- Medication Management
- Refresher on Regulations
- Complaints
- Report Writing

• All staff will engage in reflective practice at team meetings which will be scheduled on a 6 weekly basis. Staff will reflect on and share how training has impacted on their practice. Minutes of these team meetings will be available to the Integrated Services Manager/Regional Operations Officer/Director of Care.
All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The PIC and Team Leader will meet on a weekly basis to review the service, the records of these meetings will be documented with actions agreed and reviewed at the subsequent meeting.
• The Team Leader and PIC will use the Local weekly and Monthly Monitoring tools to inform these meetings.
• The PIC will adopt a structured approach to completing the Residential services Audit consistently on a monthly basis to ensure effective monitoring of completion of documentation and administrative processes within the designated centre. This will be completed by 18/12/2020 and ongoing each month. The ISM will monitor completion of same on a monthly basis.
• The PIC will ensure the Team Leaders complete the Residential services audit on a weekly basis going forward and will address any areas that need to be addressed.
• The Integrated Service Manager (ISM) will meet with the PIC on a weekly basis to review the service and monitor performance. This meeting will be documented with actions agreed and reviewed at subsequent meetings. This commenced from the 04/12/2020.
• The Provider will enhance monitoring of the service and reporting of the service performance to senior management and Board level, this enhanced approach will remain in place for the duration of the period of time that conditions remain on the registration of the service.
• A copy of this Inspection Report has been made available to the organisation's Board.
• The PIC and Integrated Services Manager (PPIM) will review the progress of the centre against the service quality improvement plan on a monthly basis. This will be completed ongoing from week commencing 04.01.2021 for a 4 month period to 04.04.2021.
• The Integrated Services manager will report on the progress of the service to the Regional Operating Officer on a weekly basis. This will be completed ongoing from week commencing 04.12.2020 for a 4 month period to 04/03/2021. The need to continue post 4 month period will be reviewed at that point.
• Team Meetings will be held on a 6 weekly basis in the centre. The Integrated Services Manager will attend team meetings on a bi monthly basis. This will be ongoing from January 2021. Team Meetings will have a standardized agenda in place going forward and will be minuted.
• A Refresher Staff Training plan will be developed to build the capability of staff. This plan will be informed by the assessed needs of residents. Refresher training will be completed by 26/03/2021.
• The PIC will implement a schedule of consistent and effective staff supervision in line with the organisation's Supervision Policy. Supervision of Team Leaders by the PIC will be conducted on a monthly basis going forward effective from December 2021. Supervision of front line team will be conducted by the Team Leaders monthly going forward with effect from January 2021. The effectiveness of supervision practices will be reviewed at weekly and subsequently monthly progress meetings between the ISM and PIC.
• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management

and the Quality and Governance Directorate.
Information from the Action Tracker will be used to inform reporting to the senior management team and the Board.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been updated and now accurately reflects the staffing arrangements in the service. This will be submitted to HIQA by 18/12/2020.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Restrictive Practice identified as part of this Inspection has been discontinued and all staff have been informed of same, documentation in respect of this has been updated to reflect the revised direction for staff practice.
• The PIC will ensure there are clear plans in place to ensure resident's needs are supported.
• As part of the service improvement plan all staff will review the organisation's Risk management and Restrictive Practice Policy. The PIC, ISM, Team Leaders and BT will complete a Service Level Restrictive Practice Self Check, the purpose of this process is to reflect on all practices in the service and determine if there are any unidentified restrictive practices occurring in the service. The BT will attend a Team Meeting to brief on the process of Restrictive Practices within the organisation. This will be completed by 15/01/2021. Restrictive Practices will form a standing agenda item on all Team Meetings going forward. Any future incidents will be reported in line with the requirements of the regulations.
All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A full review of all individual risk assessments and the Risk Register will be conducted in the service. This will be completed by the 22nd of January. The outcome of this review will be briefed to all staff to ensure a consistent understanding of Risk Management within the service. Risk Management will be form a standing agenda item at all team meetings to be held on a 6 weekly basis.

The purpose of the review is to:
- Ensure that all risks including those identified in this report are evidence based, accurate and reflective of the actual risks within the service and that the risk rating attached is proportionate to the risk.
- Where risks are identified the control measures identified are proportionate and implemented in practice.
• The risk register for the service will be updated to ensure it reflects all risks accurately. This will be completed by the 22/01/2021 and will be reviewed ongoing on a monthly basis as part of the Residential Services PIC monthly Audit.
• A risk assessment for each resident in respect of the risks posed by COVID19 will be completed with control measures identified by the 18/12/2020.
• All staff will engage in Risk Management training with the organisation's Chief Risk Officer. This will be completed by the 29/01/2021.
• Residents are currently being supported by staff on an on-going basis in relation to independently cooking and fire safety. This will be completed by the 29/01/2021.
• Risk Management will be reviewed by the Integrated Service Manager (ISM) during weekly monitoring and support meetings with the PIC. This meeting will be documented with actions agreed and reviewed at subsequent meetings.
All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

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: • A full review of the needs of each resident will be completed. An Annual Needs Screening for each resident will be completed, this will be a robust process that ensures all resident's current care and support needs are adequately assessed and clearly identified in the service. This will then be used to inform a review of resident's support plans and individual risk assessments. This will be completed by 22/01/2021. The process will ensure maximum participation of all residents in their support planning. • Staff will be briefed at team meetings to ensure a consistent understanding of residents support needs. Each keyworker will be scheduled to present at 6 weekly team meetings on their key resident to update the team on any pertinent information relating to their plans, changes etc. • The PIC and Team Leader will both audit one randomly selected plan per month. The PIC will carry out this process as part of the Residential Services PIC Monthly Audit. The purpose of the audit will be to ensure the effectiveness of current plans and to identify if activities offered and engaged in are in line with assessed needs of residents and their expressed wishes. This will commence from January 2021 and ongoing. All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • The Restrictive Practice identified as part of this Inspection in respect of a resident being required to return to the service at 10pm and restrictions on the type and quantity of alcohol they can consume has been discontinued and all staff have been informed of same, documentation in respect of this has been updated to reflect the revised direction for staff practice. • As part of the service improvement plan all staff will review the organisation's Risk management and Restrictive Practice Policy. The PIC, ISM, Team Leaders and BT will complete a Service Level Restrictive Practice Self Check, the purpose of this process is to reflect on all practices in the service and determine if there are any unidentified restrictive practices occurring the service. The BT will attend a Team Meeting to brief on the process for identifying and approving Restrictive Practices. This will be completed by 15/01/2021. Restrictive Practices will form a standing agenda item on all Team Meetings	

going forward.
• Behaviour Support Planning will form a standard agenda item on all staff meeting on a 6 weekly basis going forward.
All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A safeguarding plan has been put in place in respect of concerns of financial abuse for one resident, the plan includes guidance for staff practice in terms of actions to be taken by staff should a situation arise whereby the risk to resident is present.
• The PIC will ensure that all staff working in the service will engage in refresher training in protection, so that they would be aware of the actions to take in the event of an incident being reported in the service. This will be completed as part of the overall Refresher Training plan by the 26/03/2021.
• Through the review of individual needs assessments any other safeguarding concerns will be assessed to determine the risk and where deemed necessary measures will be taken to report concerns and develop safeguarding plans. This will be completed by 22/01/2021.
• All open Safeguarding Plans in the service will be reviewed by the 22/01/2021.
Briefings will be held with staff at team meeting to ensure all are fully & consistently aware of how to protect each resident in accordance with individual safeguarding plans. Safeguarding will form a standing agenda on Team Meetings on a 6 weekly basis going forward.
• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• As part of the service improvement plan all staff will review the organisation's Risk management and Restrictive Practice Policy. The PIC, ISM, Team Leaders and BT will complete a Service Level Restrictive Practice Self Check, the purpose of this process is to reflect on all practices in the service and determine if there are any unidentified restrictive practices occurring the service. The BT will attend a Team Meeting to brief on the process of identifying and approving Restrictive Practices. This will be completed by 15/01/2021. Restrictive Practices will form a standing agenda item on all Team Meetings going forward.
• Keyworker sessions will be facilitated for each resident on a monthly basis, part of this process will include a review with residents to determine their satisfaction with the level of autonomy and decision making they experience in their daily lives. These will be reviewed by Team Leaders on a monthly basis and will also be reviewed by the PIC on a randomly selected basis as part of the Residential Services Monthly audit.
• Guidance has been developed to guide staff practice in relation to the risk of an individual service user not safely self-medicating in the event of not returning home at night prior to staff going off duty.
All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 26/03/2021 and monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	26/03/2021
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	26/03/2021
Regulation	The person in	Not Compliant	Orange	26/03/2021

16(1)(a)	charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	26/03/2021
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.	Not Compliant	Orange	26/03/2021
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	26/03/2021

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 responding to emergencies.	Not Compliant	Orange	26/03/2021
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	26/03/2021
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	26/03/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health	Not Compliant	Orange	26/03/2021

	care professional, of the health, personal and social care needs of each 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(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	26/03/2021
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	26/03/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	26/03/2021
Regulation	The registered	Not Compliant	Orange	26/03/2021

09(2)(b)	provider shall ensure that each resident, in 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.			