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:	The Lodge
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	24 May 2022
Centre ID:	OSV-0004826
Fieldwork ID:	MON-0034049

About the designated centre

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

This designated centre provides a residential service. Two residents live in the centre on a full-time basis and each resident is provided with their own largely self-contained section of the house. Each resident has en-suite facilities in their bedroom and a separate bathroom is also available. A social model of care is provided and the staff team is comprised of social care workers and support workers; staff are present in the house at all times. Responsibility for the day to day management of the service is assigned to the person in charge supported by the lead social care worker. The service and the support provided are based on the principles of individualised service design, are tailored specifically to meet individual needs as identified through the person centred planning process.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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
Tuesday 24 May 2022	10:30hrs to 18:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

The inspection was undertaken to monitor the providers' ongoing compliance with regulatory requirements. The inspection was also undertaken in the knowledge that this service had been through a difficult and challenging period from late 2021 to early 2022 due to increased and significantly altered resident needs. The provider had liaised with HIQA (Health Information and Quality Authority) during this period and had advised HIQA a decision had been made by the provider that the designated centre was not suited to meeting these changed needs. There was a plan to provide an alternative placement. There was no definitive transfer date but a possible time-frame of September 2022.

Two residents live in this designated centre. Based on what the inspector observed, read and discussed the inspector could see how the provider had concluded that it did not have in the designated centre the arrangements needed to meet residents' needs. Changed needs and the arrangements put in place to meet them impacted on the quality and safety of the service provided to both residents living in the designated centre. For example, the house was now a much more restricted environment where residents were segregated from each other for their safety and well-being. However, the inspector also found the operation of the centre was still somewhat in crisis mode and needed to develop more proactive and responsive strategies that responded as needed to fluctuating resident needs. This was important given the fact that there was no definitive transfer date. In addition, the inspector found deficits in systems that did not adequately evidence the current model of support.

It was understandable that there was an emphasis on ensuring resident and staff safety but a better balance was needed between safety and quality of life. Much work was needed and there were many deficits in the systems that underpinned and guided the delivery of a safe quality service such as in assuring staffing arrangements, staff training, risk management, and personal planning with and for residents. There were examples where what was described to the inspector as being in place was not in place based on what the inspector observed and read. For example, in relation to the staffing levels and risk assessing community access and activities. Given the deficits identified, improvement was needed in the management and oversight of the service so that the service provided was safe but also consistently and effectively monitored so that it was the best service it could be given the limitations presented by the current living arrangements.

This inspection was unannounced. One resident was at their off-site day service and one resident was at home. Staff contacted the resident in the day service who kindly agreed to the inspector using their apartment section of the house as a base to work from. The inspector ensured to keep the apartment well-ventilated, wore an FFP2 mask and cleaned down surfaces after using them. The inspector walked through the main house several times during the day and had the opportunity to observe practice, staff and resident interactions and meet with the resident who was

at home.

The resident was very well on the day of inspection. The resident engaged through gesture, facial expression and some spoken word. The resident was very relaxed with the staff members on duty and reacted positively to the presence of the inspector in their home. The resident actively sought out the inspector by name, interacted, smiled and made good eye contact. The resident presented as quite content to be with the staff members on duty and to watch staff as they attended to some maintenance in the garden and normal routines such as cooking. The resident did not however leave the house though they made a request to do so in the late afternoon. This will be discussed in detail in the main body of the report.

The inspector met with the second resident in the evening when they returned from their day service. The resident was using their personal tablet to work on a literacy project supported by staff. Staff left the inspector and resident to speak in private. There was discussion of home and family including a recent family event they had enjoyed. The resident said they continued to enjoy knitting and attending their day service. The resident confirmed they had met with the designated safeguarding officer who had recently visited the centre. The resident had met with the very recently appointed person in charge and said she was very nice. The inspector posed some very open questions to the resident who raised no concerns or worries in response. The resident told the inspector that they were happy in their apartment, felt safe, there was nothing they wanted to change and if they had concerns they would speak to the staff.

This feedback did not reflect staff account of how the resident felt and feedback the resident had provided to inform the provider's annual review of the service. The resident was reported to be fearful of their peer, disliked and was upset by the raised noise levels that presented at times in the main house. These could be heard in the apartment. The resident on the basis of risk was very much restricted to their apartment, could not access the main house, the enclosed garden or the utility room to attend to their own laundry. Both residents were reported to have previously enjoyed a good relationship and chose to enter each others section of the house if they wished. There was little if any interaction between residents now.

The inspector did not meet with any resident representative but saw that they had responded to an invite to provide feedback to inform the provider's annual review of the service. Representatives had provided positive feedback and rated the service as excellent while also citing the difficulties and challenges in the service.

In summary, this was a service that had experienced a period of crisis due to changed and increased resident needs. This had impacted on both residents and on the staff team. There was evidence to support the provider's conclusion that the designated centre was unsuited to meeting these changed needs. However, the agreed transfer was not imminent and a full review of systems such as the process of personal planning, responding to risk, the use and review of restrictive practices, staffing arrangements and staff training was needed. Deficits in these systems did not provide adequate evidence to support how the service was currently operated. These deficits did not provide for reliable data that could be meaningfully used by

the provider to monitor and review the appropriateness of the service. Ultimately, these deficits did not provide satisfactory evidence of how the support and arrangements in place promoted resident and staff safety but also resident quality of life.

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

Capacity and capability

There were management systems in place that sought to ensure that the service provided was safe and appropriate to residents' needs. For example, as discussed in the opening section of this report the provider itself had concluded that it did not have in the designated the arrangements needed for both residents to be safe and to enjoy a good quality of life. However, in the interim improvement was needed in core areas and the deficits identified by this inspection did not provide assurance of consistent and effective management and oversight.

Restructuring of the management team was in process. Some of these changes reflected natural progression of staff but also the impact of the challenging period that had occurred in the service. A new social care worker had been appointed and the incoming person in charge officially commenced their role the day prior to this inspection. The inspector met with both the previous person in charge and the newly appointed person in charge. The inspector was assured there was clarity on roles and responsibilities and a comprehensive handover that supported continuity had taken place. Resident representatives had been advised of the changes to the management structure.

There were systems of review and oversight for monitoring the quality and safety of the service such as the review of accidents and incidents and the use of any as needed medicines. However, the inspector found that the data used to inform these reviews was not always reliable (such as the logging and recording of incidents) and, the findings of reviews were not reflected in other associated systems and records such as risk assessments. This did not demonstrate how oversight and reviews assured and improved where necessary the quality and safety of the service provided. This will be explored in more detail in the next section of this report.

A very recent internal review of the quality and safety of the service had been undertaken by the provider. The auditor very kindly spoke with the inspector during the inspection and provided an overview of the findings to the inspector. The report was in draft but had been issued to the person in charge for review including review for any factual inaccuracies. The reviewer had followed up on the actions from the previous audit completed in January 2022 and found most had been reasonably progressed. However, the inspector was advised that a substantive quality

improvement plan was to issue. The areas identified by the reviewer as requiring improvement reflected areas identified by this HIQA inspection such as the use and review of restrictive practices, risk management and personal planning.

The crisis and risk that had occurred in the service had impacted on the staff team and some turnover of staff was reported. Staff had been recruited. However, the inspector was not assured how staffing levels and arrangements were based on and met the assessed needs of both residents, any assessed risks to residents and, the design and layout of the house. For example, the inspector was advised and records seen cited the provision of two to one staffing for one resident and the provision of support to the other resident from community based staff. In effect, there were two staff duty rotas in operation one for the centre and one for the community based staff. Based on what the inspector was told and had read the inspector had an expectation that a third staff would commence duty to provide support in the apartment in the evening but did not. The inspector saw there were two staff on duty to provide support to both residents. There was no apparent defined structure to the hours of support provided in the centre by community based staff.

Just as one resident was expected to return to the house the other resident clearly articulated and repeated in the presence of the inspector that they would like to go in the car; that is to leave the house. This request was not facilitated and the response provided by staff indicated staffing levels and arrangements that were not sufficient to meet the needs of both residents.

All staff who provided support to residents did report to and were line managed by the person in charge. Therefore, the person in charge had the authority and was accountable for ensuring that all staff were appropriately supervised.

The incoming person in charge had completed a review of staff training and had put a training matrix in place. The person in charge told the inspector that this review had highlighted deficits in staff training. The recent internal review had also highlighted staff training deficits. On reviewing the training matrix the inspector saw there were significant deficits and the provider had failed to ensure all staff working in the centre had completed mandatory and required training relevant to the support they provided to residents living in this centre. These training deficits included training in safeguarding, fire safety, medicines management, manual handling, positive behavior support, the provision of intimate care, and core infection prevention and control modules.

Regulation 14: Persons in charge

The person in charge officially assumed their role in the management and oversight of this service on the day prior to this inspection. The provider had notified HIQA of this change. The person in charge had the qualifications, skills and experience needed to manage the designated centre. The person in charge had demonstrated in other designated centres their ability and capacity to provide effective leadership, management and oversight. The person in charge was open to the findings of this

inspection and understood the improvement that was needed.

Judgment: Compliant

Regulation 15: Staffing

The inspector was not assured how staffing levels and arrangements were based on and met the assessed needs of both residents, any assessed risks to residents and, the design and layout of the house. For example, the inspector was advised and records seen cited the provision of two to one staffing for one resident and the provision of support to the other resident from community based staff. Based on what the inspector observed on the evening of this inspection there were two staff on duty to provide support to both residents. In effect, there were two staff rotas in operation but no defined structure on the hours of support provided in the centre by community based staff.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had failed to ensure all staff working in the centre had completed mandatory and required training. Training deficits included training in safeguarding, fire safety, positive behaviour support, manual handling, medicines management, the provision of intimate care and, core infection prevention and control modules.

Judgment: Not compliant

Regulation 23: Governance and management

There were management systems in place that sought to ensure that the service provided was safe, and appropriate to residents' needs. This was also a service that had been impacted by and was recovering from a critical period. However, collectively these HIQA inspection findings and the level of non-compliance found with regulatory requirements did not provide assurance of consistent and effective management and oversight. Deficits were identified in core systems and arrangements that did not provide sufficient evidence as to how these arrangements ensured and assured both the quality and safety of the service provided to both residents. For example, in relation to the adequacy of the staffing arrangements and the stated risk based approach to providing support. While reviews were completed and data was collected it was not demonstrated how this assured and improved as

necessary the safety and quality of the service.

Judgment: Not compliant

Quality and safety

Based on what the inspector read, observed and was told the arrangements in this centre were not suited to the individual and collective needs of the residents. Residents were provided with separate areas of the house and their needs were diverse. Their home was quite a restricted environment where residents were segregated from each other but still lived in close proximity to each other. Escalated noise levels from the main house could be heard in the apartment. Staff reported in times of heightened anxiety and distress the resident's distress could be heard in the apartment and in neighbouring properties. Staff spoke of closing curtains so that residents could not see each other as this could trigger fear and behaviours. These arrangements were not sustainable and not conducive to promoting the well-being, welfare, dignity and quality of life of either resident.

These inspection findings (as described above for example) provided evidence as to how the provider had concluded it did not have in the designated centre the arrangements needed to meet residents' needs. There was a plan in process to transfer one resident to another service. Arrangements put in place in the interim were focused on promoting resident and staff safety and preventing behaviours of concern and risk. This was understandable and necessary but a better balance was needed between safety and resident quality of life. Better assurance was needed in core systems such as in personal planning, risk management and the use of restrictive practices to validate decisions made as to how the centre was operated and the model of support that was provided.

For example, there was a stated objective of providing for one resident a low-stimuli environment where no demands were placed on the resident such as to partake in activities or to access the community. The inspector was advised that the resident had left their home four times in the past month. This was in sharp contrast to the full and active life and range of activities the resident had enjoyed prior to the deterioration in their well-being. However, the inspector saw that the resident's personal plan including their daily schedule and their personal goals and objectives had not been reviewed in any meaningful way to reflect the resident as they now were, their changed needs, abilities, routines and circumstances. This did not provide assurance as to what, other than the objective to prevent escalated behaviours and risk, guided the residents daily routine and the consistency of support and care that was provided by staff. The resident's needs fluctuated and there was an ongoing risk for behaviour of concern. However, narrative notes created by staff over a recent period of time reflected a resident who was feeling well, reported to be in great form, complying with personal care requirements and engaging with staff in a range of activities such as listening to music, using their

personal computer and engaging in household activities. Staff were required to risk assess the possibility of community access and engagement. However, what the narratives notes did not include was a record of staff having done this, offering the resident the opportunity to leave the house or not and how the resident had responded to such suggestions.

On the day of inspection and as discussed in the previous section of this report the inspector heard the resident to say and repeat "we will go in the car". Staff advised the resident that this could not be facilitated. There was nothing to indicate that this was on the basis of any assessed risk but was directly related to the staffing levels on the day and a possible absence of guidance for staff.

The inspector found an absence of an explicit risk assessment process to guide staff to objectively assess safe community access for the resident. The inspector was advised that a memo had issued to staff advising staff that this activity was at the discretion of staff. The resident's positive behavior support plan stated that staff were to risk assess and decide if it was safe to leave the house, when to go and where to go. However, the risk assessment in place for community access was specific to the risk of COVID-19. The transport risk assessment advised staff to refer to the transport protocol. The transport protocol referred to one staff member or two staff members providing support which would not reflect the reported requirement for a two to one staff ratio.

Given the stated focus on resident safety and the high level of restrictions in use a full review of risk, it's assessment, control and the impact of controls was needed. For example, it was evident from records seen that there was inconsistency in the recording and reporting of behavior related incidents. Internal reviews of such incidents had reported a relatively low number of incidents but had concluded following incident reviews in late 2021 and for the first quarter of 2022 that the numbers reported did not reflect the number of actual incidents and near misses. This inconsistency did not provide sufficient evidence as to how the level of risk that presented in the centre was objectively assessed and monitored so as to support the risk based approach to care and support. It was also stated that these incidents were a possible trigger for increased seizure activity in a peer but this concerning conclusion was not formally addressed in the relevant risk assessment. A further example of arrangements that were inadequately risk assessed was the adequacy of the staffing levels and arrangements to meet and ensure the safety of both residents in the context of their assessed needs including the risk for falls and seizure activity.

Better correlation between risks, controls and the use of restrictive practices was needed. Better oversight of the sanctioning and use of restrictive practices was needed. Records were in place for a number of restrictive practices. However, what was not evident from the records seen was why, whether and how often some restrictive practices had been used. For example, there was a restrictive practice protocol for the covert administration of medications but it could not be confirmed for the inspector how often this practice had been used. This practice was not referenced in the medicines administration risk assessment. Likewise, a record seen referred to the administration of fluids using a syringe. This practice, why it was

needed and any and all associated risks such as the risk for aspiration was not referenced in any other record seen. Based on these inspection findings a full review of restricted community access, the reason for this and controls to ensure this was the least restrictive procedure and a last resort was needed.

There were two protocols in place for the administration of the same as needed medicine both setting out different indicators for administration. The indicator for administration in one protocol was broad and better guidance was needed to ensure consistency.

Regulation 13: General welfare and development

Based on what the inspector was told and what the inspector read the model of support was focused on promoting resident and staff safety and preventing behaviours of concern and risk. This was understandable and necessary but a better balance was needed between safety and resident quality of life.The inspector was advised that the resident had left their home four times in the past month. Narrative notes created by staff over a recent period of time reflected a resident who was feeling well and engaging with staff in a range of activities in the house such as listening to music and engaging in household activities. However, what the narrative notes did not include was a record of staff offering the resident the opportunity to leave the house or not and how the resident had responded to such suggestions. The inspector observed an interaction on inspection where a resident's request to leave the house was not facilitated.

Judgment: Not compliant

Regulation 26: Risk management procedures

Given the stated focus on resident and staff safety and the high level of restrictions in use a full review of risk, it's assessment, control and the impact of controls was needed. For example, it was evident from records seen that there was inconsistency in the recording and reporting of behaviour related incidents. This inconsistency did not provide sufficient evidence as to how the level of risk that presented in the centre was objectively assessed and monitored so as to support the risk based approach to care and support. The inspector found an absence of an explicit risk assessment process to guide staff to objectively assess safe community access for a resident. Better correlation was needed between the assessed risks of each resident, the impact of individual needs on the other and the impact of controls put in place to manage risks. Staffing levels and arrangements were inadequately risk assessed in relation to their suitability to meet and ensure the safety of both residents in the

context of their individual and collective needs. A more comprehensive assessment and plan was needed for manual handling-movement techniques in patient care. An action from a safeguarding review was for manual handing to be revisited for all staff so that the plan and practice was resident specific. Based on the records seen by the inspector there was outstanding manual handling staff training.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had concluded it did not have in the designated centre the arrangements needed to meet residents' needs. There was a plan in process to transfer one resident to another service. Based on what the inspector read, observed and was told the arrangements in this centre were not suited to the individual and collective needs of the residents. While residents were provided with separate areas of the house their needs were diverse. Their home was quite a restricted environment where residents were segregated from each other but still lived in close proximity to each other. Interim arrangements were not sustainable and not conducive to promoting the well-being, welfare, dignity and quality of life of either resident.

One resident's personal plan including their daily schedule and their personal goals and objectives had not been reviewed in any meaningful way to reflect the resident as they now were, their changed needs, abilities, routines and circumstances. This did not provide assurance as to what, other than the objective to prevent escalated behaviours and risk, guided the residents daily routine and the consistency of support and care that was provided by staff.

Judgment: Not compliant

Regulation 7: Positive behavioural support

All plans and protocols (such as the transport protocol) in relation to positive behavior support required review to ensure they reflected the residents altered needs. While there was evidence of MDT input (Multi Disciplinary Team) the resident's positive behavior support plan was dated September 2021.

Better oversight of the sanctioning and use of restrictive practices was needed. Records were in place for a number of restrictive practices. However, what was not evident from the records seen was why, whether and how often some restrictive practices had been used. For example, the covert administration of medications. A full review of restricted community access, the reason for this and controls to ensure this was the least restrictive procedure and a last resort was needed. In general

restrictive practices had been agreed and sanctioned by the local staff team. This did not provide assurance of wider oversight to ensure each restrictive practice was necessary, evidence based and a last resort. There were two protocols in place for the administration of the same as needed medicine with both setting out different indicators for administration.
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 (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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for The Lodge OSV-0004826

Inspection ID: MON-0034049

Date of inspection: 24/05/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC will review the staffing allocations and rota to ensure the assessed needs of the individuals have appropriate supports. Revised rota to be in place 31/07/2022. The PIC will review the training records and training bookings of staff to ensure all staff are appropriately trained, aware of the requirements in relation to their training and supported sufficiently where there is a waiting period for formal training. Matrix and records reviewed 10/06/2022. Bookings revised and delegated 16/06/2022. Full training review for compliance to ensure all mandatory and online training completed and inductions of new staff reviewed. 15/07/2022. The PIC will review the supervision and appraisal system for the center addressing gaps in supervision. Keyworker and SCW supervision completed 16/06/2022. New inductee supervision completed 15/06/2022. All staff supervision review will be completed with at least 1 meeting directly with the PIC. 31/07/2022. The PIC will introduce formal team meeting agendas, which address the review of systems in place to progress personal planning, responses to risk, use of restrictive practices and the staffing arrangements at the center. Staff will receive ongoing guidance in relation to their roles and responsibilities in relation to these areas of service provision. Agenda revised 16/06/2022. Meeting schedule developed to year end 27/06/2022.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and	

staff development:
The PIC will review the training records and training bookings of staff to ensure all staff are appropriately trained, aware of the requirements in relation to their training and supported sufficiently where there is a waiting period for formal training. Matrix and records reviewed 10/06/2022. Bookings revised and delegated 16/06/2022. Full team training review to ensure compliance has been achieved 15/07/2022.

The PIC has reviewed the induction process and made changes to enhance the quality of the process and the information and systems in place for guidance of staff. 15/06/2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The completed substantive quality improvement plan has been issued with respect of the provider audit. All actions to be completed as outlined therein 10/08/2022.

The supervision and appraisal of all staff to be reviewed by the PIC 31/07/2022.

PIC to chair all staff meetings to ensure revision of systems and approach to service provision proceeds as outlined in revised personal plans and assessments of need. 28/06/2022.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Record keeping system altered to ensure the capturing of qualitative information in relation to individuals experiences and assessed needs. Improved data collection to inform the planning processes, risk assessments in relation to individuals, and determine appropriate care and supports.

Assessed needs of the individuals revised and plans developed to include opportunities to acquire skills and quality of life experiences where possible. Completed planning meeting and guidance 07/06/2022.

Revised plan and daily schedule with updated support note template for capturing data

to be in place 31/07/2022.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Weekly upload of data to inform risk assessment to be commenced following newly agreed systems of recording. Organisational incident recording systems will reflect the day-to-day experience of the staff and individuals. 07/07/2022.

Quarterly review of data from updated record keeping documents to inform risk assessments to be reviewed for efficacy and enhanced as required from 31/07/2022.

Revised risk register developed 13/06/2022.
Review of risks completed with staff team including its assessment, control and impact of controls as required. 28/06/2022.
Full risk system update to be completed with associated restrictive practices 31/07/2022.
Record keeping in relation to restrictive practices to be updated and put in place 14/07/2022.

Review of data collection 31/07/2022, using revised guidance for recording put in place on 28/06/2022.
Team review scheduled 10/08/2022 to ensure levels of risk can be assessed in relation to data collected. Further revision of systems as required ensuring risk assessment is evidence based and proportionate on an ongoing basis.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Individual plan reviewed and recommendations made to address the assessed changes in needs and circumstances of the individual. Meeting held 07/06/2022 to progress the renewed approach to individual plan, which will address the guidance of the individual's daily activity and develop areas of support in relation to transition and rehabilitation.

The renewed approach to the individual's plan includes development of strategies to support transition to another service provider more appropriate to the person's needs.

Monthly meetings with provider, funding agent, psychiatrist, clinical psychologist, family representative and PIC continue to manage the intended transition. 17/06/2022 – alternative housing confirmed to be secured by the proposed future service provider. 15/07/2022 – update in relation to planned transition arrangements and timeline to be determined at the aforementioned stakeholder meeting

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Risk assessments indicating the use of restrictive practices will outline all measures taken and restriction of least impact and last resort. Use of restrictions will be recorded and data collected in relation to their use to inform ongoing assessment of risk. 31/07/2022. Restrictive practices no longer in use will be explicitly ceased and outlined in a restrictive practice register. Any additional Restrictive Practices introduced will also be noted on the restrictive practice register. 31/07/2022.

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/07/2022
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.	Not Compliant	Orange	31/07/2022
Regulation 15(4)	The person in	Not Compliant	Orange	31/07/2022

	charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.			
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.	Not Compliant	Orange	15/07/2022
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	28/06/2022
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified,	Not Compliant	Orange	31/07/2022

	and that any adverse impact such measures might have on the resident's quality of life have been considered.			
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	28/06/2022
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	15/07/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new	Not Compliant	Orange	28/06/2022

	developments.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	15/07/2022
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.	Not Compliant	Orange	31/07/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/07/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates	Not Compliant	Orange	31/07/2022

	intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			