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:	Waxwing 2
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	10 May 2021
Centre ID:	OSV-0004842
Fieldwork ID:	MON-0032734

About the designated centre

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

Waxwing 2 consists of two detached bungalows, one of which is situated in a small town with the other located a short driving distance outside the same town. This designated centre can provide a residential service for a maximum of 11 residents with intellectual disabilities, over the age of 18 and of both genders. Each resident in the centre has their own bedroom and other rooms throughout the two houses of the centre include kitchens, dining rooms, living rooms and bathrooms. Residents are supported by the person in charge, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 10 May 2021	10:00hrs to 16:50hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

On the day of inspection residents were seen to be treated well and in a respectful manner with positive feedback provided by residents and family on the services provided in the designated centre. However, documentation reviewed did suggest that there were times in the centre when some residents has been scared or frightened.

This inspection occurred during the COVID-19 pandemic with the inspector adhering to national and local guidelines. Social distancing was maintained when communicating with residents and staff while personal protective equipment (PPE) was used and the inspector's movement throughout the designated centre was restricted in so far as possible. On account of this the inspector only visited one of the two houses that made up this designated centre. While in this house the inspector was largely based in a vacant resident bedroom.

At time of the inspector's visit four residents were present in this house, three of whom were met by the inspector. One of these residents wanted to shake the inspector's hand but at the suggestion of staff waved to the inspector instead. During the inspection these residents were observed to spend time relaxing watching television while some residents also took part in arts and crafts. Records reviewed for this house also indicated that residents participated in other activities like going for walks or drives, baking and taking part in music or mindfulness sessions conducted through online video conferences.

These residents were seen to be treated in a very positive, respectful and warm manner by staff members present during the inspection. For example, it was seen that one resident was asked what music video they wanted to put on the television in the living room and this choice was respected. Another resident was observed to be very well presented during the inspection and appeared very happy when complimented on a hair bow that they were wearing.

Staff also supported residents in completing surveys in 2021 about life in the centre which covered areas such as residents' likes and dislikes, the safety of residents, staff support and COVID-19. These surveys were reviewed by the inspector and it was noted that overall positive responses were provided in them. One resident spoken with during the inspection also indicated that they liked living in their home.

However, when reviewing documentation in the centre, particularly relating to the house visited by the inspector, multiple references to residents being scared, frightened, distressed, nervous or unsettled were found relating to 2019, 2020 and 2021. It was noted that such instances were related to the mix of residents being supported in this house and there had a recent reduction in resident numbers living here. While the impacted residents' most recent feedback on their home was positive, the findings of this inspection indicated that this was not always the case.

Residents had been supported to maintain contact with their families during the COVID-19 pandemic through telephone calls or visits. It was also noted that some residents' family members had completed questionnaires on the service their relatives received while living in this designated centre. Such questionnaires covered areas like residents' personal plans and staffing. Again it was read that generally positive responses were given in these questionnaires although one family member did make reference to wanting a little more privacy when visiting. It was not clear which house of the centre this family member was referring to. In the house visited by the inspector, it was observed that parts of this house were tight on space. For example, it was seen that a staff office was located in the dining area. It was also observed that the presence of door ledges and some changes in surface levels in this house were not ideal for residents with mobility issues.

Despite this it was seen that efforts had been made to present this house in a homely manner with photographs of residents and art works completed by them on display throughout the house. Residents were also consulted in relation to the running of this house through weekly meetings that took place. This allowed residents to be given information in various areas and it was noted that residents were supported in making decisions about their care. For example, residents were supported in coming to a decision around whether they wanted to receive COVID-19 vaccines. Residents and their families were also involved in person-centred planning carried out in the centre to support the development of residents' individual personal plans.

In summary, efforts were made to give the house visited by the inspector a homely feel and residents were observed to be treated well by staff members present on the inspection. While the most recent feedback from residents and family on the services provided in the centre was positive, there were clear indications that this was not always the case.

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

Capacity and capability

Issues identified by the provider's own monitoring systems and this HIQA inspection raised concerns in relation to the overall governance of this centre. This resulted in an urgent compliance plan being issued to the provider following completion of this inspection.

The designated centre was last inspected by HIQA in April 2019 and is currently registered until December 2023. As part of the centre's current registration conditions it had a restrictive condition in place requiring the provider to complete fire safety upgrades in both houses of this centre by 30 June 2021. The provider

had previously indicated that they would not be in a position to meet this time frame and would apply to vary the date for this condition. The purpose of the current inspection was to assess the designated centre's level of compliance since its previous inspection. During this inspection it was noted that fire safety works had yet to commence and it was again indicated that the provider would apply to vary the date for completion.

Since the April 2019 HIQA inspection, it was seen that the provider had been monitoring the services provided to residents. Under the regulations the provider is required to carry out unannounced visits to the centre every 6 months to review the quality and safety of care and support. The provider had carried out four such visits since April 2019, with the process for some modified on account of COVID-19. Written reports were maintained of these visits which included actions plans for responding to issues identified. Such actions plans assigned responsibility for areas of improvement to be completed.

The inspector reviewed all four of these reports and found that they were focused on the service which residents received. However, it was noted that these reports raised concerns around the overall compliance levels that had been maintained in this designated centre since April 2019. Issues which were highlighted in these reports included assigned actions not being completed, areas such as risk management requiring priority review and instances were residents were described as being nervous, scared or frightened.

Given the nature of the issues highlighted by the provider's own monitoring systems, some of these matters were escalated to senior persons participating in management for this centre and it was seen that some actions were taken in response to these findings. For example, safeguarding procedures were enacted after it was found in an October 2019 unannounced visit that instances where some residents were clearly adversely impacted had not been considered as safeguarding concerns. However, it was of concern to HIQA that similar instances were also highlighted by a June 2020 unannounced visit while the current HIQA inspection also raised concerns around the safeguarding procedures followed in the centre and the submission of required notifications to HIQA. In addition, it is the responsibility of the provider who must also ensure that all staff working in a centre are sufficiently supported, developed and performance managed to exercise their professional responsibility for the services delivered in the centre. It was evident that the provider had not met this requirement for some key staff of this designated centre.

Given such concerns, following the completion of the inspection the provider was issued with a urgent compliance plan relating to specific regulations covering governance, notification of incidents and safeguarding. In response the provider undertook a review of all incidents occurring in the centre since the beginning of 2019. This review resulted in a number of retrospective notifications submitted to HIQA. It was also indicated that the provider would be carrying out an internal investigation relating to the centre. While the urgent compliance plan response was deemed satisfactory, it was of concern to HIQA that the issues highlighted were not

acted upon by the provider sooner.

While there were areas in need of improvement, it was found that staffing arrangements in place were appropriate to support the number of residents present at the time of inspection although this would need review in the event that resident numbers increased. The staffing arrangements were outlined in the designated centre's statement of purpose which was reviewed by the inspector. This is an important governance documents which is required by the regulations to be reviewed annually and to contain specific information relating to the running of this centre.

The statement of purpose provided was dated April 2021 but it was noted that not all of the information contained in it was current. For example, the centre's current registration conditions as outlined in its certificate of registration were not included while the room sizes for one house were not stated. In addition, when present in one house of this centre, the inspector noted that the standalone floor plans submitted as part of the centre's most recent registration renewal application indicated that an exit door was present in one resident bedroom. However on inspection the inspector noted that this exit door was not present.

Registration Regulation 5: Application for registration or renewal of registration

The floor plans submitted as part of the centre's most recent registration renewal application showed an exit door from one bedroom that was not present.

Judgment: Substantially compliant

Regulation 15: Staffing

Sufficient staffing arrangements were in place to support the residents present in the centre at the time of inspection.

Judgment: Compliant

Regulation 23: Governance and management

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed. However, it was of concern to HIQA that the issues highlighted were not acted upon by the provider sooner. While the provider was monitoring the services provided to residents, its own unannounced visit reports

raised concerns around the overall compliance levels in the designated centre since April 2019. Recurrent areas for improvement identified did not demonstrate that effective support, development and performance management of key staff was being carried out throughout this time.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was in place that had been recently reviewed but it was noted that it did not contain the most recent information as outlined in the centre's certificate of registration while the room sizes for one house were not indicated.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all incidents of a safeguarding nature and allegations of staff misconduct had been notified to HIQA. One quarterly notification for restrictive practices occurring in the designated centre had not been submitted during 2020. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed.

Judgment: Not compliant

Quality and safety

Based on the findings of this inspection, safeguarding procedures were not consistently followed in response to incidents occurring in the centre or at times when it was clear that residents were adversely impacted. Some improvement was needed in relation to fire safety and infection prevention and control.

The provider had policies and procedures in place relating to the safeguarding of residents but, when reviewing documentation for one house, there was multiple references to residents being scared, nervous or frighten between the period May 2019 to October 2019. This related to the impact that one former resident was having their peers. Safeguarding procedures were only enacted for such matters after an unannounced visit carried out by the provider in October 2019. Despite this further instances were recorded in during 2020 were residents were clearly

adversely impacted by the former resident. Again safeguarding procedures were not followed in a timely manner.

In 2021 there had also been similar instances but on these occasions it was seen that safeguarding procures had been followed with the appropriate bodies notified. It was also noted that there had been a recent reduction in the number of residents living in this house which would likely prevent such instances occurring again. However, when reviewing records of recent incidents occurring in the other house of the centre, the inspector noted records of negative interactions between residents living there. Some of these incidents had not been sufficiently considered from a safeguarding perspective in line with the providers own policy and as a result safeguarding procedures had not been followed which had the potential to adversely impact residents' safety.

It was of concern to HIQA that there was evidence across 2019, 2020 and 2021 of safeguarding procedures not being consistently applied. In light of this an urgent compliance plan was requested following completion of this inspection. In response the provider indicated that they had undertaken a review of all incidents occurring in the designated since the beginning of 2019 and had identified a number of instances where safeguarding procedures should have been followed. These were commenced retrospectively. While the urgent compliance plan response was deemed satisfactory, it was of concern to HIQA that the issues highlighted were not acted upon by the provider sooner.

Improvement was also required to ensure the safety of residents in relation to fire safety. The one house of the centre visited by the inspector was noted not to have sufficient measures for fire containment. Such measures are important to prevent the spread of fire and smoke and to ensure a protected evacuation route if required. The inspector was informed that the other house of this centre did not have sufficient fire containment measures either. It was seen though, in the house visited by the inspector, that it had other fire safety system in place including a fire alarm, emergency lighting, fire extinguishers and a fire blanket while it was observed that the fire evacuation procedures were on display in this house.

These procedures indicated that the evacuation routes for one bedroom, which had been designated as a resident’s bedroom, would require a resident using that bedroom to pass through the house’s living room if evacuating the centre. However, in the event that a fire took place in this living room there was no other evacuation route indicated. This bedroom was unoccupied at the time of inspection although it had been recently in use. The evacuation procedures in use for this bedroom required further consideration particularly if another resident came to use that bedroom. Other aspects of the premises also required review.

When reviewing risk assessments it was seen that some risk assessments were in place relating to the suitability of the house visited by inspector. While it was noted that such risk assessments required updating to reflect current information, these risk assessments highlighted that this house restricted residents given their needs and the overall size of the house. At the time of inspection four residents were living in this house and it was seen that space was limited in parts of this house, for

example a staff office was located in the dining room. This house had a maximum capacity for six residents and it was observed that space could be more limited were the house to reach full capacity.

Other risk assessments were in place relating to individual residents and matters concerning COVID-19. As part of these residents had been assessed to take part in some activities away from the centre depending on COVID-19 restrictions in place. Measures were in operation to protect residents from potential harm related to the ongoing pandemic. For example, there was regular temperature checking of residents and staff members while staff present during the inspection were observed to use PPE. Hand gels were available in the house visited by the inspector along with information on COVID-19 that was on display.

The house visited by the inspector was observed to be clean on the day of inspection and records reviewed that it was cleaned daily. However, given the ongoing COVID-19 pandemic, it is important that frequently touched surfaces are cleaned multiple times throughout the day. Records reviewed for the house visited by the inspector indicated that such cleaning was being carried out two times a day recently and it was initially indicated to the inspector that this was in line with the provider's own policies and guidance. It was subsequently confirmed by a person participating in management that this was incorrect and such cleaning should have been carried out four times a day.

COVID-19 had impacted the ability of residents to go out into the community. However, it was noted that person-centred planning carried out recently for some residents was looking at ways to engage residents in more social activities as restrictions eased. Person-centred planning informed residents' individual personal plans which were held in the centre. These are required by the regulations and should outline the supports residents are to receive. It seen from a sample of personal plans that they had been reviewed and received multidisciplinary input which is also another requirement of the regulations.

Regulation 17: Premises

Risk assessments carried out by the provider indicated that one house of this premises was restrictive to residents on account of its size and it was observed during this inspection that parts of this house were limited in space. It was also observed that the presence of door ledges and some changes in surface levels in this house were not to suited residents with mobility issues.

Judgment: Not compliant

Regulation 26: Risk management procedures

A risk register and risk assessments were in place but it was noted that the contents of some risk assessments required review to ensure that they contained current information.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Cleaning of frequently touched items in one house of the centre in response to COVID-19 was not being carried out in accordance with the provider's own policies and guidance.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Sufficient fire containment measures were not present in the two houses of this centre. The fire evacuation route and arrangements for one resident bedroom required review.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans in place which were informed by a person-centred planning process. This ensured that residents and their families were involved in personal plans which were also subject to multidisciplinary review.

Judgment: Compliant

Regulation 8: Protection

Safeguarding procedures were not consistently enacted in 2019, 2020 and 2021 which had the potential to adversely impact the safety of residents. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed. However, it was of concern to HIQA that the issues

highlighted were not acted upon by the provider sooner

Judgment: Not compliant

Regulation 9: Residents' rights

Information and support had been given to residents to make decisions on whether they wanted to receive COVID-19 vaccines. Residents were consulted about the running of this designated centre through weekly resident meetings while residents in the house visited by the inspector were seen to be treated in a respectful manner.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Waxwing 2 OSV-0004842

Inspection ID: MON-0032734

Date of inspection: 10/05/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: Application for registration or renewal of registration: • The revised plans will be forwarded to registrations at HIQA on 09/06/2021 • The Statement of purpose will be updated to include the revised floor plan 09/06/2021	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • An urgent compliance plan was issued following the inspection and returned to HIQA on 13/05/2021 • The Chief Executive was advised and sent a copy of the urgent compliance plan. • An investigation will take place to establish the facts and identify what the failings are/were in the management system. • In order to address the immediate concerns in the short term the PIC has been temporarily reassigned as a protective measure. • The PPIM/Area Manager has been appointed as PIC in the interim and an administrator will be recruited to support the PIC. • All future incidents will be reviewed by the PIC and will be consulted with the DO for a period of 6 months and will be reviewed with the PPIM thereafter. • The BOCISLR has plans, as communicated at the last monthly PIC meeting, to provide enhanced training to all PICS/PPIMS in respect of safeguarding reporting and processes.	

This will be implemented by the end of June 2021.
• Guidance in respect of reporting was issued to staff and staff were reminded that they can contact the DO directly regarding any matters of concern.
• The next 6-month unannounced inspection is scheduled for 1st June 2021 (Inspection delayed for unforeseen circumstances and will be rescheduled as a priority) and will be completed by June 30th 2021. A formal meeting will take place between the PIC, PPIM and Head of Quality to review the findings of this report and agree an action plan.
• An update on this action plan will be submitted on a monthly basis in writing by the PIC to the Director of Service and PPIM.
• Additionally, Individualised support plans are available for all persons supported based on their unique needs, including; health care plans, behavior support plans, manual handling care plans, EDS plans, safeguarding plans.
• One safeguarding plan has been revised and one safeguarding plan has been introduced since the inspection following engagement with the DO and PIC.
• There is a defined management structure outlined in the Statement of Purpose. This is a tiered management structure detailing from the Person in charge up to the Director of Services/Provider Nominee
• The roles of each manager is outlined in their job description
• Accident and Incident Monitoring will commence and will be completed monthly by the PIC/Area Manager, in consultation with the Designated Officer, to monitor and identify concerns or trends that may not have been responded to appropriately, or under the correct procedure. This will commence on 09/06/2021 for a period of 6 months and thereafter be completed by the PIC with the support of the PPIM. This review has been completed since the inspection for 2019, 2020 and 2021 (todate).
• Staff are now required to sign and date to evidence that they have read and understood the content of the Safeguarding plan for implementation, as they are issued or revised. PIC/Area Manager to oversee this, as documents are introduced or revised.
• Complaints logs to be reviewed by the PIC/Area manager monthly, to review the content of complaints, responses and the appropriateness of the procedure to the complaint. Commenced from 09/06/2021 for the previous month.
• MDT supports and referrals made to ensure that the persons supported care meets their individual needs. An MDT will be arranged for all persons supported in the centre by 30/06/2021.
• MDT for 2 residents completed on 03/06/2021
• Support and supervision of all staff members and managers to take place quarterly in line with BOCSI-LR procedures.
• Team meetings with the Area Manager & PICs take place on a weekly basis with standing agenda items including; safeguarding updates, risk management update, review of complaints, , review status of PCPs, discuss any updates of My Profile My Plan, important issues raised in relation to Persons Supported by the Service, MDT - referrals and planning, Restrictive practice review, Staffing.
• Monthly meeting with individual PIC will take place to review HIQA action plans, Unannounced inspection action plans.
• Staff meetings to take place monthly in both houses of the designated center facilitated by the PIC/Area Manager. Commenced 27/05/2021 by PIC/Area Manager. Safeguarding and Behavior support will be on the agenda for these meetings.
• All staff attend mandatory training including safeguarding training.
• Staff have access to the national BOCSI safeguarding procedure and the supporting documents and resources to make report or raise a concern about the care of any

resident
• Staff have access to managerial support including on call managers if they are unsure of what they need to do following an incident or an emerging concern.
• The Designated Officer and PIC met with the staff on 27/05/2021, in one of the residences to discuss documenting incidents and the importance of good report writing, challenging behaviors and peer to peer abuse. Definitions of abuse were also discussed and the importance of referencing the National safeguarding procedure or seeking the assistance of a manager when unsure of the next step to take.
• PIC met with staff from the second residence in the Designated Centre also on 27/05/2021 to discuss documenting incidents and the importance of good report writing, challenging behaviors and peer to peer abuse.
• The DO with the PIC visited both houses in the designed centre on 14th May 2021 and spoke to residents and staff regarding safeguarding.
• One resident, who was causing concern, had been supported to move from the designated center to a new home on 06/04/2021.
• The number of residents in one house has reduced from 6 to 4 due to transfer of resident and death of another resident. The Provider is actively engaging with the funder to reduce the overall number of residents from 6 to 5 once fire upgrade works are completed.
• Further management training to be discussed with Head of HR. Meeting scheduled for 11th June 2021.
• Application to vary to extend condition of registration in respect of fire safety due to logistical difficulties in progressing fire upgrade works will be submitted to HIQA by 11th June 2021.

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 will be updated to include the most recent information outlined in the centre's Certificate of Registration.
• The revised floor plan for of the residence including, a description of the rooms in the designated centre including their size and primary function will be updated in the Statement of Purpose
• The revised Statement of Purpose will be updated and forwarded to registrations at HIQA by 09/06/2021

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PPIM contacted the Designated Officer (DO) following discussion with the Inspector with regards to the findings of the Inspector in respect of unreported incidents.
• The DO carried out a review of the Accident Incident Report system from 1st January 2019 to present day and submitted the preliminary screening to the HSE Safeguarding and Protection Team.
• The DO met with the interim PIC on 14th May to ensure all the correct incidents are notified to the Regulator.
• A copy of the compliance plan was sent to the DO by the Director of Services in order to agree plan to review this designated centre from a safeguarding perspective so that we have assurances in respect of safeguarding of the residents.
• HSE Safeguarding and protection team informed by the DO on 11.05.2021 that an inspection found matters unreported in 2021 and that DO would undertake a review of AIRS forms within the designated centre from 01/1/2019 to present day.
• The HSE Safeguarding team have raised questions in relation to the following in the course of the discussion
o Governance and management of the designated centre
o Training needs of staff on the ground as regards reporting
o Possible neglect by the organisation.
• The HSE Safeguarding team has advised that they require a chronology of the situation and the matter will be raised with the Principal Social Worker on receipt of this report.
• A review of the Accident, incident and reporting system has taken place, complete d by the Designated Officer and reported to the Director of Services on 12th May 2021.
• All relevant incidents (12 in total) were reported to HIQA using the NF06 notification process.
• The DO with the PIC visited both houses in the designed centre on 14th May 2021 and spoke to residents and staff regarding safeguarding.
• The Designated Officer and PIC met with the staff on 27/05/2021, in one of the residences to discuss documenting incidents and the importance of good report writing, challenging behaviors and peer to peer abuse. Definitions of abuse were also discussed and the importance of referencing the National safeguarding procedure or seeking the assistance of a manager when unsure of the next step to take.
• PIC met with staff from the second residence in the Designated Centre also on 27/05/2021 to discuss documenting incidents and the importance of good report writing, challenging behaviors and peer to peer abuse.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Concerns raised by the inspector will be addressed through the fire containment works

planned for Waxwing 2.
• Specification work has been completed in consultation with the Fire Safety Engineer on both houses.
• Unfortunately there has been a delay in progressing the upgrade of the house being used as the temporary location for residents while upgrade works are taking place.
• A new Application to Vary will be submitted by June 11th 2021 requesting an extension of the current condition to the 31/12/2022.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The PIC/Area Manager will complete a full review of the risk registers of the designated centre.
• Risks in respect of safeguarding will be prioritizied.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Correct cleaning checklist in place from 04/06/2021
• Staff in both houses informed of this revised checklist and the increased cleaning requirements

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Concerns raised by the inspector will be addressed through the fire containment works planned for Waxwing 2.
• Specification work has been completed in consultation with the Fire Safety Engineer on both houses.
• Unfortunately there has been a delay in progressing the upgrade of the house being

used as the temporary location for residents while upgrade works are taking place.
• A new Application to Vary will be submitted by June 11th 2021 requesting an extension of the current condition to the 31/12/2022.
• The bedroom referred to in the report is not currently in use and there are no plans to introduce a new resident at this point to the house until such time as the fire safety upgrade works are completed.
• L1 fire panel and emergency lighting is in place and requires checks will continue to be carried out.
• Scheduled servicing takes place on the fire system and emergency lighting as legislation advises
• A Fire register is in place and the required checks are completed and documented then filed in the fire register by staff working in the centre.
• Fire extinguishers and fire blankets are in place across the centre.
• PEEPs are in place for all residents, they are reviewed on a regular basis with information regarding each resident and an outline on how staff will need to support each resident to evacuate in the event of a fire.
• Annual night time fire drill completed.
• Quarterly daytime fire drills completed.
• Assistive technology in place for one resident with a hearing impairment
• Staffing arrangements in place by night to ensure that safe evacuation can take place
• Concerns raised by the inspector will be addressed through the fire containment works planned for Waxwing 2.
• Specification work has been completed in consultation with the Fire Safety Engineer however there is a delay in commencing the work in the designated centre due to the fact that work has been delayed in the proposed alternative location for the duration of the works.
• A new Application to Vary will be submitted by June 11th 2021 requesting an extension of the current condition to the 31/12/2022

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• An urgent compliance plan was issued following the inspection and returned to HIQA on 13/05/2021
• The Chief Executive was advised and sent a copy of the urgent compliance plan.
• An investigation will take place to establish the facts and identify what the failings are/were in the management system.
• In order to address the immediate concerns in the short term the PIC has been temporarily reassigned as a protective measure.
• The PPIM/Area Manager has been appointed as PIC in the interim and an administrator will be recruited to support the PIC.
• All future incidents will be reviewed by the PIC and will be consulted with the DO for a period of 6 months and will be reviewed with the PPIM thereafter.
• The BOCISLR has plans, as communicated at the last monthly PIC meeting, to provide

enhanced training to all PICS/PPIMS in respect of safeguarding reporting and processes. This will be implemented by the end of June 2021.
• Guidance in respect of reporting was issued to PIC and staff were reminded that they can contact the DO directly regarding any matters of concern.
• The next 6-month unannounced inspection is scheduled for 1st June 2021 (Inspection delayed for unforeseen circumstances and will be rescheduled as a priority) and will be completed by June 30th 2021. A formal meeting will take place between the PIC, PPIM and Head of Quality to review the findings of this report and agree an action plan.
• An update on this action plan will be submitted on a monthly basis in writing by the PIC to the Director of Service and PPIM.
• The PPIM contacted the Designated Officer (DO) following discussion with the Inspector with regards to the findings of the Inspector in respect of unreported incidents.
• The DO carried out a review of the Accident Incident Report system from 1st January 2019 to present day and submitted the preliminary screening to the HSE Safeguarding and Protection Team.
• The DO met with the interim PIC on 14th May to ensure all the correct incidents are notified to the Regulator.
• A copy of the compliance plan was sent to the DO by the Director of Services in order to agree plan to review this designated centre from a safeguarding perspective so that we have assurances in respect of safeguarding of the residents.
• HSE Safeguarding and protection team informed by the DO on 11.05.2021 that an inspection found matters unreported in 2021 and that DO would undertake a review of AIRS forms within the designated centre from 01/1/2019 to present day.
• The HSE Safeguarding team have raised questions in relation to the following in the course of the discussion
• Governance and management of the designated centre
• Training needs of staff on the ground as regards reporting
• Possible neglect by the organisation within the designated centre.
• The HSE Safeguarding team has advised that they require a chronology of the situation and the matter will be raised with the Principal Social Worker on receipt of this report.
• A review of the Accident, incident and reporting system has taken place, complete d by the Designated Officer and reported to the Director of Services on 12th May 2021.
• All relevant incidents (12 in total) were reported to HIQA using the NF06 notification process.
• The DO with the PIC visited both houses in the designed centre on 14th May 2021 and spoke to residents and staff regarding safeguarding.
• The Designated Officer and PIC met with the staff on 27/05/2021, in one of the residences to discuss documenting incidents and the importance of good report writing, challenging behaviors and peer to peer abuse. Definitions of abuse were also discussed and the importance of referencing the National safeguarding procedure or seeking the assistance of a manager when unsure of the next step to take.
• PIC met with staff from the second residence in the Designated Centre also on 27/05/2021 to discuss documenting incidents and the importance of good report writing, challenging behaviors and peer to peer abuse.
• All staff attend mandatory training including safeguarding training.
• Staff have access to the national BOCSI safeguarding procedure and the supporting

documents and resources to make report or raise a concern about the care of any resident
• Staff have access to managerial support including on call managers if they are unsure of what they need to do following an incident or an emerging concern.
• One resident, who was causing concern, had been supported to move from the designated center to a new home on 06/04/2021.
• The number of residents in one house has reduced from 6 to 4 due to transfer of resident and death of another resident. The Provider is actively engaging with the funder to reduce the overall number of residents from 6 to 5 once fire upgrade works are completed.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	09/06/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	30/06/2021

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	30/06/2021
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.	Substantially Compliant	Yellow	31/08/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated	Substantially Compliant	Yellow	04/06/2021

	infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	10/05/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	09/06/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation,	Not Compliant	Orange	14/05/2021

	suspected or confirmed, of abuse of any resident.			
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.	Not Compliant	Orange	14/05/2021
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.	Substantially Compliant	Yellow	30/06/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/06/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in	Not Compliant	Orange	19/05/2021

	relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			