Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Iona House
Name of provider:	Praxis Care
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	28 August 2018
Centre ID:	OSV-0003415
Fieldwork ID:	MON-0024437

About the designated centre

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

Iona House provides residential services to adults with an intellectual disability. The service provides nine full-time residential placements to adults who are over 18 years of age and have an intellectual disability who may have associated physical disability. At the time of inspection, all residents were male. Some residents were provided with individualised day programmes which incorporate home based activities. The centre is a purpose built bungalow close to a nearby town, with easy access to all local amenities and shops. The centre comprised of eight single bedrooms including five with en-suite facilities. In addition, the centre also consisted of a one bedded self contained apartment. There are gardens to the rear of the centre. Residents are supported by a staff team that includes a manager, team leaders and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

To prepare for this inspection the inspector or 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
28 August 2018	10:30hrs to 19:30hrs	Andrew Mooney	Lead
28 August 2018	10:30hrs to 19:30hrs	Conan O'Hara	Support

Views of people who use the service

In response to the needs of residents the inspectors did not engage verbally with all residents for any extended time. The inspectors judgements in relation to the views of the people who use the service, relied upon observation of residents, documentation, brief interactions with residents and discussions with staff.

On the day of inspection, the inspectors met with nine of the residents who used the service. Some residents spoke with the inspectors and noted that they were happy in the centre. In addition, while inspectors observed that some residents appeared comfortable in their home, inspectors also observed that some residents appeared anxious during busy times of the day.

Capacity and capability

Overall, there was an clearly defined management structure in place in the centre and management systems were in place. However, these required improvement to ensure that the service provided was safe and of good quality.

There were clearly defined management structures which identified the lines of authority and accountability within the centre. There was a suitably qualified and experienced Person In Charge in place. The provider had systems in place to monitor and review the quality of services provided in the centre that were in accordance with the requirements of the regulations. The provider carried out six-monthly unannounced visits, an annual review of the quality and safety of care in the centre and developed a Quality Improvement Plan, which outlined areas for improvement within the centre. The inspectors found that these audits failed to identify some gaps in service provision. In addition, improvements were required in relation to the annual review. While, the annual review notes some consultation with residents, improvements in the level of consultation with residents or representatives was required as it was unclear if all residents or representatives had an opportunity to engage with the annual review. The annual review was also not available to residents on the day of inspection.

Since the last inspection in July 2016, the centre had admitted new residents to the centre. The inspectors reviewed the admission process and found that admission policy and practices required improvement to take account of the need to protect residents from abuse by their peers. The pre admission assessment identified concerns regarding risk of injury to current residents and additional resources were allocated to the centre. Despite the additional resources there has been an increase in peer to peer incidents

There was a planned and actual roster maintained in the centre. However, the roster did not contain full names of staff. This was addressed on the day of inspection. The inspectors reviewed a sample of the staff roster and found that there was a sufficient number of staff in place. However, improvements were

required in the continuity of care and support. There were currently 1.5 whole time equivalent vacancies in the staffing complement of the centre and there was a reliance on the use of relief staff.

Staff training records showed that not all staff had up-to-date training including safeguarding vulnerable adults and fire safety. In addition, staff had not received training to support residents with identified needs such as eating and drinking. Concerns regarding staff training were also identified on the previous inspection.

The previous inspection identified that not all contracts of care were signed by residents or their representative. On review of a sample of contracts of care, the inspectors noted that this was addressed. Each resident had an agreement in place which outlined the service provided. However, the fees set out in these agreements were inconsistently applied. This led to some residents being charged for the use of the bus and others being exempt from these charges.

The inspectors reviewed a sample of incidents in the centre and found that the centre notified the Authority as required by the regulations.

The inspectors reviewed a sample of policies in the centre and found that the centre had the policies and procedures in place as outlined under Schedule 5 of the Regulations.

Regulation 14: Persons in charge

There was a suitably qualified and experienced Person In Charge in place who demonstrated good knowledge of the residents and the regulations.

Judgment: Compliant

Regulation 15: Staffing

There was a sufficient number of staff in place in the centre to meet the care and support needs of residents. However, there was an over-reliance on the use of relief staff.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The admissions process did not take account of the need to protect residents from

abuse by their peers. Residents also had a written and agreed contracts in place however there were inconsistent practices in place in relation to the fees to be charged.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed a sample of incidents in the centre and found that the centre notified the Authority as required by the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The inspectors reviewed a sample of policies in the centre and found that the centre had the policies and procedures in place as outlined under Schedule 5 of the Regulations.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had up-to-date training including safeguarding vulnerable adults and fire safety. In addition, staff had not received training to support residents with identified needs.

Judgment: Not compliant

Regulation 23: Governance and management

Taking into account the cumulative findings of this report the inspectors were not assured that the current systems of governance and management in place were effective in ensuring a safe or appropriate service to the residents.

The audits failed to identify some gaps in service provision. In addition,it was unclear if the annual review allowed for consultation with all residents or

representatives and it was not available to residents on the day of inspection.

Judgment: Not compliant

Quality and safety

The designated centres quality and safety was negatively affected as a result of the poor implementation of some organisational systems. In particular improvements were required with the maintenance of the premises, fire safety management, protection against abuse and positive behaviour supports.

There had been new admissions to the centre since the last inspection. On review of a sample of admission documentation and from speaking with members of the management team, inspectors were not assured that they were appropriate. Inspectors found that admissions procedure was impacting negatively on the quality of life of the residents and did not adequately take account of the need to protect residents from abuse by their peers. Whilst the centre had policies and procedures on the prevention, detection and management of abuse. Inspectors found that not all residents were adequately protected. Furthermore, due to the continued frequency and pattern of these incidents, inspectors found the providers responses were ineffective.

The inspectors completed a walk through of the centre and found that improvements were required in the internal decor of the centre, communal storage and the management of maintenance issues. Inspectors observed residents bedrooms were personalised to residents tastes. However, areas of paint and decor in parts of the centre were worn and in need of repair. The centre manager noted that painting of the centre was due to be completed. There was a lack of storage space and inspectors observed a number of items stored in communal areas. Inspectors reviewed the maintenance log and while there was evidence of issues being identified and addressed. That being said, inspectors identified additional areas in need of repair such as broken window handles and damaged plaster. The garden to the rear of the centre was not inviting and was not kept in a homely manner. Inspectors observed wooden posts from an old fence that were still in place across the centre of the garden. There was also rubbish bags observed around the boundary of the property. In addition, inspectors observed rubbish, cigarette butts and old electrical equipment on and around the grounds of the centre. Similar issues were identified during the previous inspection.

The centre had systems in place for the management of fire. However, some improvements were required. Inspectors found that the equipment such as extinguishers, emergency lighting and fire alarm were appropriately serviced. The centre had personal emergency evacuation plans in place for each resident which outlined how to support each resident in the event of an evacuation. However, the inspectors found that a fire door and side gate on the route of evacuation were

locked. Inspectors sought immediate assurances regarding this and it was addressed on the day of inspection. While regular fire drills were occurring, they not demonstrate that all residents could be evacuated when the the lowest number of staff were on duty.

The inspectors reviewed a sample of personal plans and found that there was a comprehensive assessment used to identify the individual health, personal and social care needs of each resident. The outcome of these assessments was used to inform an associated plan of care for the residents and this was recorded as the residents' personal plan. The plans were reviewed monthly and the centre completed an annual review of the effectiveness of the plan. Inspectors found that residents were supported to experience their best possible health. The plans reviewed outlined residents needs and demonstrated that residents had access to a General Practitioner and a range of allied health professionals.

Positive behaviour support plans were in place for residents where required. The inspectors reviewed a sample of positive behaviour plans which identified and guided staff on supporting residents. However, improvements were required in the consistent implementation of these plans. Some staff spoken with were unclear on the current interventions in place. Additionally, it was unclear if the interventions prescribed were reviewed for effectiveness. As some resident support plans did not effectively redirect them from persistent property damage.

Restrictive practices were assessed and regularly reviewed to ensure they were appropriate. However, inspectors identified one locked door which was not identified as a restrictive practice and therefore not appropriately assessed and reviewed.

Residents communication needs were assessed and communication plans were in place. Inspectors found that residents had access to TV and radio. However, the centre did not provide Internet for residents use.

There were systems in place regarding the management of residents finances however it required review. Residents' had limited access to and control of their own finances. While the centre maintained a limited amount of residents' finances on site, residents did not have full access to there disability allowance had to travel 20 minutes to access their finances.

The centre maintained a risk register which outlined the risks in place in the centre such as slips, trips and falls, staff shortages and behaviour. In addition, individualised risk assessments were completed for residents including mobility and eating and swallowing. However, the inspectors found that the risk assessments required review, as they did not accurately reflect the current risks within the centre.

The centre had a policy in place in relation to medication and there was established medication practices in place. The inspectors found that medication was appropriately stored and systems were in place for the return of out-of-date or unused medication to the local pharmacy.There were arrangements in place for the management of controlled medication. Staff were appropriately trained in the administration of medication within the centre. However, inspectors reviewed a

sample of residents' prescriptions and administration records and identified that improvements were required. In the sample reviewed, the administration of medication was not accurately recorded on a number of occasions. Therefore, it was not evident that medication was administered as prescribed.

Regulation 12: Personal possessions

There were systems in place regarding the management of residents finances. However, residents did not have adequate access to and control of their own finances.

Judgment: Not compliant

Regulation 26: Risk management procedures

Risk assessments required review, as they did not accurately reflect the current risks within the centre

Judgment: Not compliant

Regulation 28: Fire precautions

The fire management systems in place required improvement. A fire door and side gate on a evacuation route were locked. Fire drills did not demonstrate that all residents could be evacuated with the lowest number of staff on duty.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment used to identify the individual health, personal and social care needs of each resident. The outcome of these assessments was used to inform an associated plan of care for the residents and this was recorded as the residents' personal plan. The plans were reviewed monthly and the centre completed an annual review of the effectiveness of the plan.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to experience their best possible health. Residents had access to a General Practitioner and a range of allied health professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans were in place for residents where required. However, improvements were required in the consistent implementation of these plans. Additionally, it was unclear if the interventions prescribed were reviewed for effectiveness.

Also, inspectors identified one locked door which was not identified as a restrictive practice and therefore not appropriately assessed and reviewed.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that not all residents were adequately protected. Furthermore, due to the continued frequency and pattern of these incidents, inspectors found the providers responses were ineffective.

Judgment: Not compliant

Regulation 17: Premises

Improvements were required throughout the premises. Areas of paint and decor in parts of the centre were worn and in need of repair. There was a lack of communal storage. Improvements were also required in the management of maintenance issues and the disposal of general waste.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Improvements were required in the recording practices relating to the safe administration of medication.

Judgment: Not compliant

Regulation 10: Communication

Residents did not have access to the Internet.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 17: Premises	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 10: Communication	Substantially compliant

Compliance Plan for Iona House OSV-0003415

Inspection ID: MON-0024437

Date of inspection: 28/08/2018

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 Registered Provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. The Team Leader compliment for the designated centre is 4.5 WTE, the .5 vacancy on the day of the inspection was filled on 01.09.18. The Support worker compliment for the designated centre is 8.6 WTE, on the day of the inspection there was 1 WTE vacancies, this post has been offered and accepted by a successful candidate. • The Registered Provider has ensured that there is a bank of regular relief staff which is utilised to cover instances of annual leave, training, sickness and unfilled vacancies as required. • The PIC has amended the Designated Centre's planned and actual rota to reflect staff's full names, positions held, contacted hours and actual hours worked as per regulation 15 (4) completed on 28.08.18. • The Registered Provider has ensured the Rota Guidelines Policy has been amended to reflect requirements as per Regulation 15 (4) to ensure learning across the organization 17.09.18. • The Registered Provider has cascaded the updated policy to all PIC's of Designated Center's across the organisation on 19.09.18. • The Registered Provider will revise the induction checklist and ensure this is completed and on file in respect of all new staff in each centre to ensure continuity of care and support at all times. This will be in place by 30.10.18.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and	

contract for the provision of services:

- 24(1)(b) The Registered Provider will ensure that admission policies and practices take account of the need to protect residents from abuse by their peers. The Registered Provider has ensured this by creating a service user placement compatibility guidance policy issued on 29.01.18. The Registered Provider has also created a compatibility risk assessment issued on 01.02.18 to be completed as part of the admission process for any new referrals to any Designated Centre.

- The Registered Provider will ensure that a compatibility risk assessment is completed in respect of any resident's placements which pre-date this policy and will take appropriate action by 16.11.18.

- The Registered Provider has drafted a new Service User on Service User abuse policy, this will ensure both the perpetrator and victim of abuse is identified and appropriate action taken following 1 incident and escalated internally following subsequent incidents of peer to peer abuse. This draft policy will be issued no later than 31.10.18.

- 24(4)(a) The Registered Provider has ensured that all contracts of care for all residents residing in the designated centre have been reviewed in line with the Residential Support Services Maintenance and Accommodation Contributions –General Implementation Guidelines as issued on 2.4.18.

- The Person in Charge has reviewed the financial audit in respect of each resident to ensure there are consistent practices in place relating to all fees charged to residents and in line with statutory regulations. Completed 28.9.18.

- The Registered Provider has ensured the Person in Charge has reviewed all transport agreements in the centre to also ensure consistency of charges are implemented in line with organisational policy - Resident's Transport Policy. Completed 28.9.18.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

- 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:

- 2 Staff require HSE safeguarding training, which has been scheduled for 09.10.18.

- The Person In Charge has ensured that all permanent staff are fully compliant in fire drills training which was completed on 01.09.18

- There is currently 1 relief staff requiring Fire Drill training, the Person In Charge has scheduled this for 10.10.18 when the staff member is next on shift.

- The Person In Charge has scheduled for all staff to complete Feds training which will provide them with the knowledge to support residents with identified needs in respect of eating and drinking. The Person In Charge will ensure all staff at the Designated Centre has completed same by 10.10.18.

- The Registered Provider will ensure all staff who support residents in respect of eating and drinking complete FEDS training, as a scheme specific mandatory training going forward.

- The Registered Provider will request that a number of Praxis Learning and Development Managers are trained in safeguarding of vulnerable adults train the trainers, which will enable the organisation to respond promptly to staff training needs in this area.

- The Registered Provider has revised the Monthly Monitoring Visit Report, completed by the Head of Operations to ensure training due to expire within 3 months is identified for action. Completed on 1/10/18.

Regulation 23: Governance and management	Not Compliant

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

- 23(1)(c) The Registered Provider will ensure that the consultation with residents and their representatives is evidenced and included in the annual review report.

- The Registered Provider will ensure that as part of the annual review process a family forum meeting will be scheduled in advance of the annual review in which all families will be invited to attend. The Head of Operations will be in attendance at this forum to be available for a consultation process with all families.

- The Registered Provider will ensure that all residents and their representatives are in receipt of Praxis Care's annual stakeholder survey and Praxis Care annual service user survey in advance of the annual review. All feedback and action plans will be addressed as part of the annual review process.

- The Registered Provider has drafted a Service User On Service User Abuse Policy. This will be issued by 31.10.18.

- The Registered Provider will ensure the compatibility policy and risk assessment in use since January 2018 is implemented in respect of all residents who's placements pre-date this policy and appropriate action taken. To be completed by 16.11.18

- The Registered Provider will ensure the Multiple Concern form will be completed in the event of more than 1 notification of abuse, and escalated internally for appropriate action.

- The Registered Provider has revised the Monthly Monitoring Visit process completed by the Head of Operations in respect of all centres, to ensure while it reviews

notifications and safeguarding concerns in the month, it now reviews frequency and pattern and action required. Completed 01/10/18.

- Regulation 23(2)(b)The Registered Provider has ensured that the annual review is available for all residents and their representatives at the designated centre. The annual review for the designated centre was received on 31.08.18 and will be discussed at the residents meeting on 29.09.18.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

- Regulation 12(1) The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.
- The Registered Provider has previously made every effort to access Bank Accounts for all residents, due to difficulty accessing same, finances are managed through PPP accounts. The PIC will make every effort once again and ensure applications are submitted to open personal savings accounts. If successful arrangements will be made to redirect their Disability Allowance and their savings to these new accounts.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

- 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.
- The Registered Provider will ensure that the risk register for the designated centre has been reviewed on 5.10.18 to reflect the current risks in the centre.
- The PIC will ensure the risk register is reviewed monthly or as required to ensure all known and new with the appropriate rating.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- Regulation 28(3)(d)- The Registered Provider has made adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.
- The person in charge has ensured that a thumb lock has been fitted to the required fire door on 04.09.18.

- The person in charge removed the lock on the side gate on 28.08.18, this was replaced with a combination lock on 19.09.18, the restrictive practice register has been updated to reflect this and will be reported to the regulatory body via quarterly returns.

- Regulation 28(4)(b) The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

- The Registered Provider has ensured that a minimum staffing level fire drill was completed on 30/08/18. The Registered Provider has ensured that a night time drill was completed 31/08/18. The Registered Provider will ensure that these fire drills are completed annually in line with regulation 28.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- 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.

- The Registered Provider in future, will ensure that in respect of any resident with complex needs any updates to Positive Behaviour Support Plans is communicated to all staff in the forum of a staff meeting within 5 working days of the plan being changed, all changes will also be communicated via the daily handover procedure and monthly supervisions.

- The Registered Provider will ensure all interventions are reviewed for effectiveness as part of the Positive Behaviour Support Plan review process and documentation is available to evidence same. See template as at 1.10.18.

- The Registered Provider has ensured that the behavioral consultant has reviewed Iona11 Positive Behaviour Support Plan on 04.09.18.

- The Registered Provider has ensured all changes to the Positive Behaviour Support Plan have been discussed at a staff meeting on 19.09.18.
- The Registered Provider will ensure that all staff receive training in the required Positive Behaviour Support Plan for all new admission to the centre in advance of the admission date.

- The Registered Provider has ensured that a cover sheet is in place for all Positive Behaviour Support Plan whereby staff sign that they have read and understood same.

- The Registered Provider will ensure a database is in place stipulating the frequency of Behavioural Reviews in respect of each resident and highlighting reviews required to

be completed annually as a minimum.

- 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.

- The Registered Provider has ensured that all restrictive practices implemented in the centre are now recorded as per regulation 7 and will be reviewed quarterly and reported to the Chief Inspector through the quarterly returns process.

- The Registered Provider has ensured that as part of the review process of all Positive Behaviour Support Plan's, this will include completion of new review tool to evidence the effectiveness of the interventions.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- The Registered Provider will ensure a full review of the current Positive Behaviour Support Plan is undertaken and completed by 15.10.18 in respect of Iona11.

- The Registered Provider where reasonably possible has put in place an additional staff resource to support the residents within the centre and ensure they are protected from the risk of abuse. Resource is in place from 4pm – 12am, Monday – Friday and 5 additional hours on Saturday and Sunday as from 17.9.18.

- The Registered Provider upon completing the compatibility risk assessments in respect of Iona 11 has convened an MDT meeting on 8.10.18 to discuss protection, support and future plans.

- The Registered provider will ensure that the Positive Behaviour support team will visit the centre monthly as a minimum to review the Positive Behaviour Support Plan and ensure consistent implementation of same for an initial period of 3 months.

- The Person in Charge completes weekly activity charts in respect of Iona 11 as from 17.9.18 and in respect of all residents as from 8.10.18 to ensure positive engagement in social and community activities.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

- 17(1)(b)The Registered Provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. The Registered Provider will ensure that the general waste is removed a minimum of 3 times per week by an external maintenance company, 30.08.18.

- The Registered Provider has ensured that the broken window handle was repaired

24.09.18

- The Registered Provider has ensured that the handover procedure and cleaning rota was updated to reflect the cleaning of the external grounds of the designated centre in line with revised arrangements.

- The Registered Provider will ensure the painting and re-plastering of the designated centre as set out in regulation 17 will be completed by 12.10.18

- The Registered Provider has ensured that the fence posts have been removed from the garden 08.09.18

- The Registered Provider has ensured that the unused electrical appliance have been removed from the designated centre 29.08.18

- Regulation 17(7) The Registered Provider has made provision for the matters set out in Schedule 6- by ensuring storage areas are kept clean and tidy and giving reasonable space to residents.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- Regulation 29(4)(b) The person in charge shall ensure that the designated center has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

- The Person In Charge has amended the handover proforma to ensure that any changes to the administration of medication and changes to Kardex will be clearly detailed and communicated to all staff daily. Completed 1.10.18.

- The Person In Charge will continue to carry out monthly medication audits, and Head of operations will complete medication assessment during monthly monitoring inspections.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

- The Person In Charge will ensure that Internet is sought and that all residents have access to same. External line for internet has been fitted on 14/09/18, all residents will have internet access available to them from 30.11.18

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 10(3)(a)	The registered provider shall ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.	Substantially Compliant	Yellow	30/11/2018
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	15/01/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	19/11/2018
Regulation 15(4)	The person in 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.	Substantially Compliant	Yellow	01/09/2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have	Not Compliant	Orange	10/10/2018

	access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/10/2018
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	16/11/2018
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Not Compliant	Orange	29/09/2018
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Orange	16/11/2018
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident	Not Compliant	Orange	28/09/2018

	in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			
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	05/10/2018
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	Red	19/09/2018
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/08/2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	01/10/2018
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each	Not Compliant	Orange	01/10/2018

	resident, or his or her representative, and are reviewed as part of the personal planning process.			
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.	Substantially Compliant	Yellow	28/09/2018
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	15/10/2018