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:	MooreHaven Centre
Name of provider:	MooreHaven Centre (Tipperary) Designated Activity Company
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	17 July 2018
Centre ID:	OSV-0003723
Fieldwork ID:	MON-0023888

About the designated centre

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

MooreHaven is a designated centre located in Co. Tipperary which provides residential care for adults over the age of 18 years. The centre provides supports to 18 full-time residents both male and female with an intellectual disability and autism. Respite support can be afforded to one service user at the one time. The centre is comprised of four dwellings in close proximity to local amenities and facilities within a town center. The service operates on a 24 hour, seven days a week basis with staff present within the centre to support residents.

The following information outlines some additional data on this centre.

Current registration end date:	26/04/2021
Number of residents on the date of inspection:	18

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
17 July 2018	09:30hrs to 17:30hrs	Laura O'Sullivan	Lead

Views of people who use the service

The inspector did not meet with residents on the day of inspection as they were availing of a day service and were not present within the centre. However, residents were observed interacting with management throughout the day in positive manner whilst in their day service.

It was noted in documentation that one resident expressed their dissatisfaction with the choice of activities afforded to them due to staffing levels that cause them to have to join their peers on activities.

Capacity and capability

While many examples of good practice were observed the capacity of the provider to put effective management arrangements in place and to address non-compliance was found to require improvement.

Staff were very knowledgeable of the needs of residents currently availing of the service within the centre and spoke of them in a respectful and dignified manner. However, the inspector found that the current operational management systems in the centre impacted on the capability of the provider to deliver an effective service. Management systems in place were not adequately robust to monitor and review service provision and required review. A number of actions relating to the previous inspection remained outstanding. This did not demonstrate that the provider could sustainably address issues of non-compliances which were known to them.

While there was a clear governance structure in place, the provider had not demonstrated that the arrangements for the person in charge and person participating in management were effective to allow them to fulfill their statutory responsibilities, as set out in the Regulations. The arrangements in place did not support oversight in areas such as auditing, risk management and notification of incidents. This also impacted on the quality and safety of care delivered to residents as set out in this report.

Quality assurance measures were reviewed as part of the inspection. These duties were the delegated responsibility of both the person in charge and the person involved in management. Auditing and monitoring systems were not implemented with action plans not in place to ensure the delivery of high-quality, person centred care. For example, the registered provider had not ensured the implementation of an annual review of the centre as required by regulation. Therefore the provider did not demonstrate the ability to self identify issues and proactively address areas

which required improvement.

A six monthly unannounced visit had been implemented by the registered provider representative in May 2018. However, the provider had not shown that this process was utilised to improve the service. Measures had not been put in place to disseminate this process to staff and the governance structure in place. The process did not show an effective system was in place to review the evolving needs of residents and ensure that resources were deployed effectively and efficiently. For example, as part of the six monthly visit a resident had expressed dissatisfaction and raised a concern about how staff had interacted with them. There was not clear evidence that this was adequately addressed or that learning was achieved following the concern being raised. Also, this had not been notified to the chief inspector as required.

There was some evidence which showed that the provider acted promptly to address findings from the previous inspection. Staffing arrangements in a number of houses within the centre had been reviewed to reflect the changing needs of the residents. Residents now had full access to their home seven days a week with staffing in place to afford support both day and night.

Staffing arrangements, however, did require further review to ensure that the supports afforded to residents were person centred in nature and that choice was promoted in all aspects of the individuals life. This was particularly pertinent where limited staff resources had impacted on the ability of residents to engage in activities of their choice.

Staff supervision arrangements were also not adequately addressed since the last inspection, despite the provider giving an undertaking to do so. The person in charge had not ensured effective systems were in place for the effective supervision of staff. No formal supervisions were implemented. Due to lack of supervision the inspector could not be assured that the workforce was organised and managed within the centre to ensure all staff had the required skills and competencies to respond to the residents' individual needs and aspirations.

Staff training records were reviewed by the inspector and overall it was evident that these were managed well. A training need in relation to safe administration of medication had been addressed promptly following last inspection. Systems were in place to facilitate staff to attend training sessions with some staff requiring refresher training in fire and safeguarding. Improvements were required to ensure that all staff had received training to support residents in areas such as manual handling to support residents at risk of falls.

Subsequent to the last inspection the registered provider had ensured the revision of a service provision agreement between the provider and the resident.This document now clearly outlines all services to be afforded in line with all fees to be incurred.This document remained unsigned by residents and representative since its review in March 2018 and this required improvement. The admission criteria and process was clearly detailed within the statement of purpose.

The registered provider had not fully addressed the requirement for all policies and

procedures on the matters set out in Schedule 5 of the Regulations. These policies and procedures are required under the regulations to ensure staff are provided with guidance on the provision of a safe effective service for residents. A number of polices which had been identified as requiring review as part of the last inspection remained in draft format and were not operational on the day of inspection. For example, the medication management policy and provision of personal intimate care. Following the completion of the review process of a policy the inspector could not be assured that the updated information was distributed to staff. The distribution of policies required review to ensure that staff understand and utilise policies to deliver a high standard of care.

Overall the provider had not demonstrate that they could respond to areas of non compliance in an effective and sustainable way.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge to the designated centre. This person possessed the required skills and knowledge.

Due to the current governance arrangements the inspector was not satisfied that role of person in charge was organised and resourced to ensure effective delivery of care and administration of the centre.

Judgment: Not compliant

Regulation 15: Staffing

The staffing arrangements required review to meet the assessed needs residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had not ensured that all staff had access to appropriate training, including refresher training.

No effective system was in place to ensure that staff received formal supervision.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not put effective management systems in place. The provider failed to implement plans to address areas of non-compliance.

Current management systems were not effective in ensuring the service provided is safe, appropriate to the residents' needs, consistent and effectively monitored.

The registered provider did not have systems in place for the implementation of an annual review as required under the regulations.

The registered provider had ensured the implementation of a six monthly unannounced visit to the centre. However, this was not comprehensive in nature and the provider had not shown that this process was utilised to improve the service.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had ensured the development of a service provision agreement which clearly outlines all services to be afforded in line with fees to be incurred. However, this document had not been signed by the resident/representatives.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development of a statement of purpose. This included information as required under schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not ensured the notification of all required adverse events

to the chief inspector.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had not ensured the preparation in writing of all required policies and procedures as set out in Schedule 5 of the regulations. All policies were not available to staff on the day of inspection in order to guide safe, consistent practice in important areas of service delivery.

Judgment: Substantially compliant

Quality and safety

The inspector reviewed the quality and safety of the service being provided and found good practice in a number of areas. Residents were engaged in their communities and opportunities for employment and social engagement.

Residents were also consulted in the running of their houses at residents' meetings which were held regularly and discussed such items as the weekly food planner, activities and household tasks to be completed. Some improvements had taken place since the previous inspection with increased opportunities for social activities for a number of residents. However, to ensure this increased opportunity of participation in meaningful activation was promoted for all, further assessment and development of appropriate individualised goals was required. Furthermore, a number of non-compliance from previous inspection had not been addressed.

The person in charge had not ensured effective systems were in place for the on-going development and review of individualised personal plans for residents availing of the service within the centre. As part of previous inspection it was identified that improvements were required in this area. This action remained outstanding with only one personal plan review complete. An updated template had been developed; nonetheless this was only operational for one resident. This template was holistic in nature and did reflect the life of the resident. Where multidisciplinary support was required such a physiotherapy or occupational therapy, a log was now maintained by the person in charge of all referrals. To ensure the support needs of all residents were clear the remaining individualised personal plans required updating.

Good practice was found in relation to health care. The registered provider had ensured that each resident was supported to achieve the best possible health in a variety of ways, including a nutritious diet and access to health care professionals. As required staff member's facilitated and supported residents to attend health care

related appointments.

Overall, the person in charge had ensured effective systems were in place for the safe receipt, storage and administration of medical products. Residents were afforded a choice of pharmacist and this choice was respected. Improvements were required to ensure the systems in place for the prescribing of medications were adhered to by all staff with regard to transcribing of medications. Systems were required to ensure that all staff were aware of current procedures and reported any discrepancies in a timely manner to prevent the risk of medication error and risk of harm to the resident. The person participating in management and person in charge were actively addressing this at the time of inspection with a medication management policy in draft format to cover these areas.

The provider had some effective systems in place to safeguard residents from abuse. An organisational policy was in place which gave guidance for staff on procedures to adhere to should a concern arise. A designated officer was allocated, with their contact details displayed in a prominent place. Residents were treated with respect by staff and management. Safeguarding plans were developed to ensure the on-going safety of residents was maintained when a concern arose. However, the provider had not demonstrated that a concern raised by one resident was addressed appropriately. Improvements were required to ensure that when residents raised a concern that this was actively addressed in an effective, prompt manner in accordance with local and national policy. This was required to ensure the safety and wellbeing of all residents was endorsed at all times.

Procedures had not been developed to ensure the intimate care support needs of resident's were clearly documented with each individuals' personal plans to ensure guidance was available for staff and care were supported in a dignified manner. An intimate care need policy remained in draft format therefore was not in operation at the time of inspection.

From speaking with staff risk was largely being well managed within the centre. Staff could articulate the support needs required to promote residents safety. In combination with staff knowledge a low level of risk related incidents occurred. However, due to lack of effective risk management procedures the inspector could not be assured that safety of all would remain uncompromised and effective supports were in place to minimise the risks present. The provider had not ensured effective systems were in place for the on-going review and identification of risk within the centre. The provider was not proactive in addressing risk as a number of risks identified by inspectors in previous inspection remained un-assessed. These risks which had been identified remained unrated therefore learning from incidents and review of adverse events was not effective.

Overall a restraint-free environment was encouraged within the centre with the promotion of residents' free movement within their home. There was a reduction in the use of restrictive interventions since the last monitoring event. However some areas requiring improvement remained. Where an environmental or chemical restrictive intervention was utilised, such as the use of an audio monitoring device at night to monitor seizure activity, the rationale for the use was

not documented within the personal plan with no recording of its use.
The registered provider had not ensured the use of restrictive practice was done so in line with local policy, as this policy remained in draft format and was not operational on the day of inspection. This required review to ensure the dignity and privacy of all residents was promoted at all times.

The registered provider had ensured effective systems were in place for the prevention and detection of fire. Fire safety systems were in place as required and fire equipment was serviced quarterly. Staff completed daily and weekly checks to ensure fire exits were clear for example and that equipment was present and in working order. Fire evacuation drills were implemented and documented on a three monthly basis; conversely no night time evacuation drill had been implemented to ensure safe evacuation procedures were in place for all residents both day and night in line with personal emergency evacuation plans.

The person in charge had ensured measures were now in place for the protection against infection. A cleaning schedule had been developed and staff implemented this. The centre presented as a clean warm environment which was decorated in line with residents unique interests and taste.

Regulation 17: Premises

Two houses were visited as part of the inspection. Both houses were clean and tastefully decorated in line with the residents needs and preferences.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had not ensured effective systems were in place for the ongoing review and identification of risk within the centre. A number of previously identified risks remained un-addressed for example the presence of an open fire/stove.

A risk register was in place however, this required review to ensure all risks were accurately risk rated and current control measures were utilised with additional measures addressed as required.

Judgment: Not compliant

Regulation 27: Protection against infection

The registered provider had effective systems in place for the protection against infection.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured effective systems were in place for the detection of fire. Fire safety systems were in place as required and fire equipment was serviced quarterly.

Fire evacuation drills were implemented, however no night time evacuation drill had been implemented to ensure safe evacuation procedures were in place.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Overall, the person in charge had ensured effective systems were in place for the safe receipt, storage and ordering of medical products. Improvements were required to ensure the systems in place for the prescribing of medications were adhered to by all staff with regard to transcribing of medications

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had not ensured effective systems were in place for the on-going development and review of individualised personal plans for residents availing of the service within the centre.

Personal plans did not guide the care of residents.

An updated template had been developed; nonetheless this was only operational for one resident.

Judgment: Not compliant

Regulation 6: Health care

Residents were facilitated to attend health care related appointments by staff members.

Recommendations from relevant health care professionals were followed through.

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall, the centre operated a restrictive free environment. However, the provider had not ensured the development of local policy relating to the use of restrictive practice. The use of restrictive practice was not documented to ensure the rationale for its use was clear and all restrictive practice was utilised in the least restrictive manner for the shortest duration necessary.

Judgment: Not compliant

Regulation 8: Protection

The inspector could not be assured that all residents were protected from all forms of abuse. All staff had not received appropriate training in the area of safeguarding. A concern submitted by a resident was not adequately investigated with appropriate action taken.

The person in charge had not ensured the development of intimate care guidelines for residents.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were consulted about the operation of the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for MooreHaven Centre OSV-0003723

Inspection ID: MON-0023888

Date of inspection: 17/07/2018

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Reg 14(2) There is a full time equivalent of 39 hours protected admin time going into the role of person in charge through the role of the person in charge and deputy person in charge.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Reg 15(1) Prior planning of activities through residents' meetings which are held weekly and also through the person centred planning process will prompt the need for additional support to be arranged.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Reg 16(1)(a) A training log is in place with all of the training courses completed by each staff member. Refresher training in MAPA, safeguarding, manual handling and fire safety has been scheduled for August 2018. The person in charge will manage the system to ensure that the mandatory training will happen within the timeframe. Reg 16(1)(b) Staff supervision has commenced under a new format and all staff will have had their initial supervisory meeting under the new format by 31st Aug 2018. Staff Supervision part shall be added to Training and Development Policy and the policy shall be renamed 'Staff Training /Development and Staff Supervision Policy' by 30/11/2018. Continuous supervision will be done in line with organizational policy.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The arrangements in place for the person in charge and deputy person in charge are there is a whole time equivalent for protected administration, a new staff supervisory system is in place for all levels.

Reg 23(1)(b) A governance and management team has been established on statutory Regulations and standards under a terms of reference. The goal is to ensure MooreHaven is in compliance with the statutory Regulations for adults with an intellectual disability and that all standards are being met.

Reg 23(1)© In order to provide a person centred quality service to residents we support, a body of work has been done to put in place a more robust set of policies to guide staff in their daily work, to ensure a quality of delivery to residents. The following list outlines the policy work and the timelines:-
A more comprehensive policy is in place for:-
Use of Restrictive practices, since 20/07/2018;
Personal / Intimate care, since 20/07/2018;
Medication Management, since 16/08/2018 (policy is distributed and training is to be delivered on the application, operational roll out by 14/09/2018.)
The following policies have been reviewed and updated _Complaints Policy, since 04/08/2018; MooreHaven's Safeguarding Residents from Abuse in the Residential Home, including Service User to Service User Policy, since 04/08/2018 and Risk Management Policy since 14/08/2018.
Work shall be done on the following policy areas:-

1. Positive Behaviour Support, this shall be added to Managing Behaviours that Challenge Policy and the policy is to be renamed 'Positive Behaviour Support/ Managing Behaviours that Challenge Policy' by 30 November 2018;
2. An additional element in relation to staff supervision shall be added to the Staff Training and Development Policy and the policy shall be renamed 'Staff Training & Development and Staff Supervision Policy' by 30/11/2018.
3. A policy on lone workers shall be put in place by 30/11/2018 and in the interim a risk management plan is in place.

The service will ensure robust auditing and monitoring systems are in place for key performance areas , for example, medication management, risk management, notification of incidents and safety for residents. This will be achieved through the oversight of the governance and management team.

Reg 23(1)(d)&(f) Annual review report for 2018 is completed and a copy is available in each of the residential homes since 13/08/2018. The annual report will be discussed at

the weekly residential meetings facilitated by the staff and any feedback will be taken on board, feedback will be given to the person in charge.

Reg 23(1)(e) Resident and family representatives are invited to a meeting to discuss the contents of the annual review report. Registered provider is to meet with residents and their family member on 22nd 23rd or 24th August 2018 to gain feedback.

Reg 23(2)(a) &(b) An unannounced six month visit shall be conducted by the due date in November 2018 and a copy shall be made available to residents and their representatives and the chief inspector. A substantial action plan will be formulated from the report to action any areas of improvement.

Reg 23(3)(a) Staff supervision has started using a new format to guide the staff supervision meeting. All residential staff will have had their initial staff supervision meeting under the new format by 31/08/2018.

Reg 23(3)(b) 'Complaint policy' and Vulnerable Adults at Risk of Abuse policy' have been revised and updated to ensure a robust system for reporting and management of complaints and for complaints that contain a concern of abuse i.e.

1. A revised internal reporting form is now accessible to all staff as part of the Compaints Policy
2. When the designated officer is on leave, the designation of the deputy do has been allocated accordingly
3. Training has taken place and is to be completed by 31st August on safeguarding vulnerable persons awareness programme
4. Flowcharts are displayed in each residential house on the steps staff are to follow should a resident make a complaint and if the complaint contains a concern of abuse.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

Reg 24(3) A copy of the revised 'Contract for Services Policy' was provided to residents by person in charge and deputy person in charge when the new contract terms were explained to the resident. Residents have signed the new contract and contract is signed by registered provider or person in charge on behalf of MooreHaven, contract is held in the resident's personal file.

An easy to read version is to be put in place to ensure it is accessible to the resident, by 12/10/2018.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Reg 31(1)(f) MooreHaven's Complaints Policy and MooreHaven's Safeguarding Residents from Abuse in the Residential Home including Service User to Service User policy have been revised showing the steps to be taken for reporting complaints. A complaint that has a concern of abuse is dealt with under MooreHaven's safeguarding policy. The person in charge is responsible for notifying HIQA with a NF06 or NF07 form within 3 working days and the designated officer will complete the preliminary screening form to be sent to HSE Safeguarding.
The revised policies have clearly illustrated the pathways in the form of a flowchart for both a complaint and a concern of abuse.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

Reg 04(1) A more comprehensive policy is in place for:-
Use of Restrictive practices, since 20/07/2018;
Personal / Intimate care, since 20/07/2018;
Medication Management, since 16/08/2018 (policy is distributed and training is to be delivered on the application, operational roll out by 14/09/2018.)

The following policies have been reviewed and updated _Complaints Policy, since 04/08/2018; Centre's Safeguarding Residents from Abuse in the Residential Home including Service User to Service User Policy, since 04/08/2018 and Risk Management Policy since 14/08/2018.
Work shall be done on the following policy areas:-

Positive Behaviour Support, this shall be added to Managing Behaviours that Challenge Policy and the policy is to be renamed 'Positive Behaviour Support/ Managing Behaviours that Challenge Policy' by 30 November 2018;
An additional element shall be added to the Staff Training and Development Policy and the policy shall be renamed 'Staff Training & Development and Staff Supervision Policy' by 30/11/2018.

4. A policy on lone workers shall be put in place by 30/11/2018 and in the interim a risk management plan is in place.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The overall aim is to learn from serious incidents or adverse events involving residents.

Reg 26(d)(1) Risk management policy has been reviewed and revised with the addition of a separate section, paragraph 'MooreHaven's Residential Services'. The system for dealing with risks in the residential service now has a separate incident log register and a separate risk register. Risk ratings from 10 upwards shall be escalated to the Risk and Quality committee by the person in charge or by the person participating in management ppim. There is a new form_ 'escalated risk feedback form' which shall be completed as part of the system in place for managing escalated risks.

Reg 26(1)(e) Risk control measures were reviewed for presentation to the risk and quality meeting held on 16/08/2018. Risks ranked at 10 or above were brought to the committee on the escalated risk feedback form by the person participating in management. No changes were made to the measures adopted balancing the resident's quality of life and the requirement to control the risk for the safety of the resident. One of the measures is for review at the restrictive practice review committee due to be held on 25th August 2018.

Reg 26(2)
Centre's risk management policy was reviewed and updated on 14/08/2018 to ensure a more robust system for the management of risk. Centre's Risk & Quality committee is a subcommittee of the Board that meets regularly to review and to manage risk within the Centre. Person participating in management or person in charge reports directly to the risk and quality committee to escalate up risks with a rating of 10 or more through a risk escalation form documenting the risk and feedback received from the committee.
The system for responding to emergencies is as outlined in the MoooreHaven Emergency Planning Policy.
The risk and quality committee meet every six to eight weeks, or as often as is required.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Reg 28(3)(d) A night fire drill was completed in the four residential homes on 25/07/2018. Each resident has a personal emergency evacuation plan.
Reg 28(4)(a) Regular fire drills are being held monthly.
Refresher training is provided in first aid fire- fighting equipment and on fire safety management.
Fire alarm systems are checked by an independent contractor on a quarterly basis, checks are logged in the fire log file in the residential home.

Reg 28 (4)(b) Staff are residents are aware of the procedure to be followed in the event of a fire, through their participation in the regular fire drills.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The goal is to ensure the safe administration of medication to all residents.

Reg 29(4)(b) A revised medication management policy has been distributed on 16th August providing for the transportation, receipt, storage, safe administration and overall management of the medication system. Staff training shall be provided on the new medication policy and on the application of the practices into the workplace by 14th Sept 2018.
One of the local pharmacies has agreed to do a six monthly medication audit on MooreHaven's medication management system.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The person is at the centre of their personal plan and their needs and wishes are of paramount importance and with this in mind the following measures are being reviewed and implemented accordingly.
Reg 05 Health action plans are part of the personal plan which are in place. An annual health check assessment will be complete for all residents by 31st August 2018 and the emerging health needs will be actioned accordingly.
Personal plans for the 18 residents are being completed under a new format shall be in place by 31st Aug 2018 for all residents.
An easy to read version of all requested and relevant personal plans will be put in place by 21st Dec 2018.
Personal plan is reviewed annually by the person in charge or sooner ensuring multi-disciplinary recommendations are incorporated into the support plans. An auditing system will be put in place by 21/12/2018 to ensure the effectiveness of the personal plan.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Centre promotes a restrictive free environment where residents are at the center of any decision making in relation to their livers.

Reg 07(4) A new restrictive practice policy is in place which includes a register of restrictive practices, logs of when each restrictive practice is used and a protocol form that shows the rational for having this restrictive practice in place. There is now a restrictive practice review committee that will review all restrictive practices and the first meeting of the review committee is due to be held on 25th August 2018.

Reg 07(5)(b) The person in charge shall ensure the resident's quality of life is maintained and that any new restrictive practice will be actioned through the policy.

Reg 07 (5)© Any new restrictive practice will be guided by the core principles of a. putting in place the least restrictive practice and b. it will be in place for the shortest duration necessary.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The goal is to provide a qualitative person centred service, tailored to meet the unique support needs of the resident, for personal, intimate care to be provided in a dignified manner, with respect for the resident. In general, residents self care needs are met by residents, who are able to look after their daily self care needs on their own. All residents have an intimate care plan in their personal plan.

Reg 08 (1) An intimate care policy is in place whereby each resident has an intimate care needs assessment and an intimate care plan. The needs assessment is used to ascertain the level of support provided in their intimate care plan. Self care programmes are part of MooreHaven's day service which residents attend and the training reinforces the importance of self care. Job coaches provide coaching and mentoring to residents who are going out on work experience, on the importance of personal presentation and personal hygiene. Traffic training is a core part of training for residents to be careful to protect themselves when crossing the road, using the safe cross code. Personal protective equipment training is provided to residents working in catering and other work areas requiring their use for example woodwork, carpentry. Manual handing training is provided to residents involved in lifting. Individual risk assessments are in place with identified support plans.

Reg 08(2) It is acknowledged that the Centre has learnt from the way a complaint was dealt with recently. The complaint came to light in an interview held with a resident during the six months unannounced visit by person conducting the six month unannounced visit, who was meeting with residents to get their views on the service. The complaint was documented and dealt with locally through an investigation with the staff involved and the resident, and measures were put in place with weekly actions. However, it is recognized the complaint should have been escalated to HSE safeguarding and HIQA. A new system is now in place where complaints policy and the vulnerable adults at risk of abuse policy have been revised to deal with any complaint that has a concern of abuse, to escalate it to national level. This was an isolated incident as the Centre has used the escalation routes for other concerns of abuse. The system is now tightened to ensure a concern of abuse is automatically dealt with through the national avenues- HSE safeguarding preliminary screening and HIQA notification of a concern of

abuse, completing NF06 or NF07 forms, as appropriate.
The Centre has reflected on its practices and has put more robust systems in place.

MooreHaven has systems in place to protect the resident from all forms of abuse. A concern of abuse is dealt with through MooreHaven's Vulnerable Adults at Risk of Abuse policy at both a local and national level, i.e. through HSE safeguarding and HIQA notification on the concern of abuse. A complaint, separate from a concern of abuse will be dealt with through the Complaints Policy.

A revised medication management system is in place to ensure the safe administration of medication to residents. A medication auditing system is in place to check working practices against the policy standard. All medical appointments are recorded in the resident's personal plan and any recommendations inform the development of support plans.

A restraint free environment is encouraged within MooreHaven. A comprehensive restrictive practice policy is now in place to ensure the least restrictive practice is used for the shortest possible time and that any use of a restrictive practice is only used as a last resort. A restrictive practice review committee is in place and the first meeting of the review committee is due to be held on 25th August 2018.

A robust risk management system is now in place consisting of:-

1. Risk assessments, risk ratings and measures, actions taken to reduce the risk
2. All incidents are recorded in
3. a separate residential incident log and are risk rated;
4. Risks with a rating of 10 upwards are escalated by person participating in management or person in charge through the 'escalated risk feedback form' to the risk and quality committee.

An open culture is promoted within the Centre where residents are supported to make their views known, to make decisions, to air concerns, to make a complaint. For example this can be facilitated through the weekly residential meetings. An independent advocate through the National Advocacy Service is promoted through posters in the residential homes advertising the service with the name and telephone number of the national advocate. MooreHaven's aim is for the resident to reach their personal potential within a supportive environment where the resident feels safe and protected.

Reg 08(4) The investigation of a concern of abuse will be through an independent party, put in place and initiated by the person in charge or by the registered provider should the person in charge be the subject of the concern of abuse.

Reg 08(6) Where a resident requires personal intimate care, their intimate care plan will state the level of intimate care required to meet the resident's intimate care needs. The safeguarding measures in place are: all staff are qualified and have garda vetting, they are all trained in safeguarding vulnerable persons awareness programme. All staff are qualified and current staff were offered the opportunity to upskill to attend peronal/ intimate care training. Personal, intimate care is provided in a dignified manner.

By ensuring a robust system in relation to this, the internal form is used 'notification of

suspected or witnesses abuse' to document the concern of abuse. The form is accessible to all staff, a deputy designated officer has been put in place to provide the cover when the designated officer is not at work. The plan is to hold regular meetings with the designated officer, deputy designated officer and the person in charge to monitor and manage all safeguarding issues. There is an internal flow chart to guide staff in the reporting of a complaint or a concern of abuse in the appendix to the revised Complaints Policy.

Reg 07 (7) The person in charge has arranged for all staff to attend safeguarding vulnerable persons awareness programme, all residential staff will have attended the programme by 30th August 2018.

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Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	17/08/2018
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/09/2018

Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/08/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/08/2018
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	17/08/2018
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	19/10/2018
Regulation 23(1)(d)	The registered provider shall ensure that there	Not Compliant	Orange	08/08/2018

	is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	13/08/2018
Regulation 23(1)(f)	The registered provider shall ensure that that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Not Compliant	Orange	13/08/2018
Regulation 23(2)(a)	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 prepare a written report on the safety and quality of care and support provided in the centre and	Substantially Compliant	Yellow	10/11/2018

	put a plan in place to address any concerns regarding the standard of care and support.			
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.	Substantially Compliant	Yellow	16/11/2018
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.	Substantially Compliant	Yellow	31/08/2018

Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	04/08/2018
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	12/10/2018
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	14/08/2018
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of	Substantially Compliant	Yellow	16/08/2018

	Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	14/08/2018
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.	Substantially Compliant	Yellow	25/07/2018
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures,	Substantially Compliant	Yellow	31/08/2018

	building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
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.	Substantially Compliant	Yellow	25/07/2018
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.	Substantially Compliant	Yellow	31/08/2018

Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Substantially Compliant	Yellow	04/08/2018
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/11/2018
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	21/12/2018
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/11/2021
Regulation 05(1)(b)	The person in charge shall	Not Compliant	Orange	31/08/2018

	ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/08/2018
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Orange	30/11/2018
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances,	Substantially Compliant	Yellow	30/08/2019

	which review shall be multidisciplinary.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/11/2019
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/08/2019
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a	Substantially Compliant	Yellow	30/08/2019

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	04/09/2019
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	04/09/2019
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	04/09/2019
Regulation 05(8)	The person in charge shall	Not Compliant	Orange	04/09/2019

	ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	25/08/2018
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	25/08/2018
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration	Not Compliant	Orange	25/08/2018

	necessary, is used.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	15/08/2018
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	14/08/2018
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	14/08/2018
Regulation 08(4)	Where the person in charge is the subject of an incident, allegation or suspicion of abuse, the registered provider shall investigate the matter or nominate a third party who is suitable to investigate the matter.	Not Compliant	Orange	14/08/2018
Regulation 08(6)	The person in charge shall have safeguarding measures in place	Not Compliant	Orange	14/08/2018

	to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.			
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	30/08/2018