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:	Antoine House
Name of provider:	Health Service Executive
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	08 November 2018
Centre ID:	OSV-0005751
Fieldwork ID:	MON-0024551

About the designated centre

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

Antoine House is a large detached bungalow situated in a large town in County Monaghan. The property was purpose built by a parents and friends association. The property is leased by the Health Service Executive (HSE). Five residents live in this community home and are supported by a nurse led team 24 hours a day. Each resident has their own bedroom with en suite facilities. The property is spacious and modernised with a large garden to the rear of the property. Most of the residents attend day services in the community and one resident is being supported using the new directions model of care in order to provide meaningful day activities during the day. There is a full time person in charge in the centre who is a qualified nurse. Transport is provided in the centre so as residents can avail of community facilities if they wish.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
08 November 2018	00:00hrs to 00:00hrs	Anna Doyle	Lead

Views of people who use the service

The inspector met all of the residents that lived in the centre. One resident engaged with the inspector throughout the inspection and spoke about things that they liked to do.

Two of the residents said that they were happy living in the centre and other residents chose not to speak to the inspector. The inspector observed that staff engaged with those residents in a respectful manner. All of the residents with the exception of two were attending external day services on the day of the inspection.

In the evening time residents were observed to be sitting at the dining room table with staff while they awaited their evening meal. They were talking about the events of their day.

Capacity and capability

This centre was registered as a new build in July 2108. This inspection was to follow up and ensure that the registered provider was meeting the requirements of the regulations since the residents had transitioned to the centre. It was also in response to information received by the Health Information and Quality Authority (HIQA) which had outlined some concerns about the quality of services provided in the centre.

Overall the inspector found that some of the information received was substantiated and that improvements were required in a number of regulations inspected. Particularly in relation to the amount of environmental restrictions in the centre which was infringing on residents access to areas of their home, positive behaviour supports, staffing levels and some residents' rights.

There was a clearly defined management structure in place in the centre. The person in charge was not present on the day of the inspection, but the assistant director of nursing (ADON) whom the person in charge reported to was present for some of the day along with another ADON and the disability manager.

Staff spoke positively about the support they received from the person in charge and senior managers. Staff meetings were reported to be held regularly in the centre although these minutes were not all available in the centre. The staff team had undergone some changes over the last few weeks. This was due to staff who had moved temporarily to this centre to support residents with their transition had now returned to their previous centre and were being replaced with permanent staff

in the centre. Given these changes, along with the ongoing issues in the centre, it was identified that staff required more frequent support and supervision in the centre in order to meet the needs of the residents.

There were mechanisms in place to review the quality and safety of care. For example, a number of audits had taken place, which included a quality improvement plan outlining areas of improvement required in the centre. A sample of actions identified from this audit were found to have been completed. The provider was also aware of their responsibility to complete unannounced quality and safety reviews and an annual review on the quality and safety of care in the centre.

The staff team consisted of nursing staff and health care assistants. Staff had been provided with training to meet the needs of the residents. This included mandatory training, basic life support and how to respond to behaviours of concern. Further training was also scheduled to take place to provide further guidance to staff in this area. Staff including the person in charge received supervision to raise concerns.

However, the provider had not employed the full compliment of staff as originally outlined in the statement of purpose which had informed the decision to register the centre. There had also been no review of this to assure that residents needs could be met in the centre. The inspector found that from speaking to staff and on review of the residents assessed needs in the centre, there were times when it was not clear whether all needs could be met. For example, two residents were assessed as requiring two staff to support them with personal care. However, there were only four staff on duty to support five residents during the day and two staff at night.

A complaints policy was available in the centre. This policy and the HSE policy on ' Your Service Your Say' guided the management of complaints in the centre. A complaints log was maintained in the centre. However, the records maintained did not always fully detail the actions taken or whether the complainant was fully satisfied with the outcome of the complaint.

Residents had contracts of care which outlined the fees and services to be provided, which from a sample viewed had been signed by the resident or their family representative.

Regulation 15: Staffing

The provider had not employed the full compliment of staff as originally outlined in the statement of purpose which had informed the decision to register the centre.There had also been no review of this to assure that residents needs could be met in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had been provided with training to meet the needs of the residents. This included mandatory training, basic life support and how to respond to behaviours of concern. Further training was also scheduled to take place to provide further guidance to staff in this area. Staff including the person in charge received supervision to raise concerns.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the designated centre and contained the information set out in the regulations and HIQA guidance documents.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that given the ongoing issues in the centre regular team meetings were required in order to support staff to meet the residents needs in the centre.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Residents had contracts of care which outlined the fees and services to be provided, which from a sample viewed had been signed by the resident or their family representative.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a Statement of Purpose for the centre which

contained the information set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector was satisfied from a review of the incidents logged in the centre, that most of the incidents had been notified to HIQA. However a number of restrictions in place in the centre, that had not been identified as such and therefore were not notified. This included wardrobes being locked, residents clothes being locked in a separate area from their bedroom and restricted access to communal areas.

Judgment: Substantially compliant

Regulation 32: Notification of periods when the person in charge is absent

The registered provider was aware of their responsibilities

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The registered provider was aware of their responsibilities under the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The records maintained in response to complaints raised were not consistently maintained.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policies and procedures required under Schedule 5 of the regulations were available to staff in the centre.

Judgment: Compliant

Quality and safety

Overall significant improvements were required in a number of areas to ensure that the services provided were achieving a safe, quality service for the residents in the centre. This was primarily due to ongoing safeguarding issues in the centre which was resulting in a significant increase in the requirement to implement restrictions for residents to access areas of their home in order to maintain their safety.

The inspector found that the provider was responding to safeguarding concerns in the centre which were all related to the impact some residents' behaviours of concern were having on other residents in the centre. While the provider was implementing safeguards to keep residents safe, these safeguards were restrictive and were impacting on residents' rights to access their own home. For, example safeguards implemented included residents being confined to areas of the centre during certain periods. Kitchen doors and dining room doors had to be locked, one sitting room was not accessible to residents and the alternative room provided was not conducive to a homely environment.

The inspector acknowledges that a team meeting had been held to discuss this at the beginning of October 2018 and a plan of action had been agreed to address this. Some of these plans included adapting and modifying the layout of the centre in order ensure residents had access to their home.

Residents who required support with behaviours of concern had a support plan in place to guide practice. Improvements were required in some of those viewed as the plans did not fully outline the use of some physical holds in the centre. Staff spoken to were not fully aware of these either.

One residents plan has also not been reviewed after an unplanned restriction had been implemented in response to behaviours of concern. The inspector also found that there was a number of restrictions in place in the centre, that had not been identified as such. This included wardrobes being locked, residents clothes being locked in a separate area from their bedroom, communal areas being restricted.

There were fire management systems in place to ensure a safe evacuation of the centre. Two fire drills had been completed since the centre had opened which provided assurances that residents could be evacuated in a timely manner.

However, learning from these fire drills were not consistently implemented.

Risk management processes were in place in the centre. A copy of all incidents occurring in the centre was maintained. From a sample viewed, the inspector found that all incidents were reviewed and actions were taken to mitigate risks.

The premises were new and each resident had their own bedroom with en suite bathrooms. Adequate storage facilities and communal space was available. However, as already highlighted, there were areas of the centre that residents could not access in the centre in order to keep them safe.

Each resident had a personal plan in place, which included an assessment of need which had been recently updated. From, a sample viewed, residents who had identified needs, had support plans developed to outline how their needs should be met. These support plans were reviewed by the staff in the centre.

Residents had communication plans in place. However, they did not have access to a speech and language therapist in order to enhance their communication skills.

The inspector observed that residents were treated with dignity and respect in the centre. However, the inspector found that issues pertaining to one residents care and support needs had been discussed at a meeting with attendees who should not have been involved in the matter. The inspector found that this was not upholding the residents right to confidentiality.

Regulation 10: Communication

Residents do not have access to a speech and language therapist. The provider is in the process of addressing this.

Judgment: Substantially compliant

Regulation 17: Premises

The premises met the requirements of the regulations. However, the layout of the centre was not suitable to meet the needs of all of the residents. The provider had identified that some modifications were required to the layout of the centre prior to this inspection and had a plan in place to address this.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management processes were in place in the centre. A copy of all incidents occurring in the centre was maintained. From a sample viewed, the inspector found that all incidents were reviewed and actions were taken to mitigate risks.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had procedures and systems in place for the management of healthcare associated infections.

Judgment: Compliant

Regulation 28: Fire precautions

Learning from fire drills were not consistently implemented.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place, which included an assessment of need which had been recently updated.

Judgment: Compliant

Regulation 7: Positive behavioural support

Improvements were required in some positive behaviour support plans viewed as they did not fully outline the use of some physical holds used. Staff spoken to were not fully aware of these either.

One residents plan has also not been reviewed after an unplanned restriction had

been implemented in response to behaviours of concern.

Safeguards implemented in response to behaviours of concern, were restrictive and were impacting on the residents right to access their own home.

Judgment: Not compliant

Regulation 8: Protection

All staff had completed training in safeguarding vulnerable adults. Staff spoken to were aware of what constituted abuse. All allegations of abuse were reported and responded to in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Issues pertaining to one residents care and support needs had been discussed at a meeting with attendees who should not have been involved in the matter. The inspector found that this was not upholding the residents right to confidentiality.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Antoine House OSV-0005751

Inspection ID: MON-0024551

Date of inspection: 08/11/2018

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: Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider has ensured that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents and the statement of purpose. There is the required nursing care provided as per the statement of purpose and assessed needs of the residents. The registered provider has ensured that resident receive continuity of care and support and all staff are employed are full time. There is 24 hours nursing support provided . The person in charge has ensured that all information in relation to schedule 2 have been obtained In response to the area of non-compliance found under this Regulation 15(1) The statement of Purpose has been reviewed to reflect the whole time equivalents for the Centre. The staffing roster has been reviewed for this centre to ensure it meets the needs of all residents Completed : 10-12-2018	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider has ensured that the Designated Centre is resourced to ensure	

the effective delivery of care and support in accordance with the statement of purpose. 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. The registered provider has ensured 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. The registered provider will ensure an annual review of the quality and safety of care and support in the designated Centre and that it will be available for residents and their representatives and will be available to residents.
The registered provider will carry out an unannounced visit to the designated Centre at least once every six months and prepare a written report on the safety and quality of care and support provided in the Centre and put a plan in place to address any concerns regarding the standard of care and support. This will be made available on request to the residents and the chief Inspector. The registered provider ensures that effective arrangement is 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. The registered provider has arrangements in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

In response to the area of non-compliance found under this Regulation 23(3) (A)

The PIC will have team meetings scheduled monthly to address any issues within the Centre. Staff meeting held on the 27-11-2018. Next meeting scheduled for 21-12-2018

Completion date : 27-11-2018 and ongoing

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The person in Charge will gave the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the centre:
1) The unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre
2) An outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre
3) Any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place
4) Any serious injury to a resident which requires immediate medical or hospital treatment
5) Any unexplained absence of a resident from the designated centre
6) Any allegation of misconduct by the registered provider or by staff
7) Any occasion where the registered provider becomes aware that a member of staff is

the subject of review by a professional body

The person in charge will ensure that a written report is provided to the chief inspector at the end of each quarter, of each calendar year, in relation to and of the following incidents occurring in the designated centre:
Any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.
Any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or teat of equipment
Where there is a recurring pattern of theft or burglary
Any injury to a resident not required to be notified through NF09
Any deaths, including cause of death, not required to be notified under the 3 day notifications
Any other adverse incident the chief inspector may prescribe.

If no incidents have been notified the registered provider will notified the chief inspector of this on a six monthly.

In response to the area of non-compliance found under this Regulation 31(3) (A)
The person in charge will include and record all restrictive practices and return them on the quarterly returns to the chief Inspector. These will be submitted on the next Quarterly returns in January 2019

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The registered provider has made available an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and:
a. ensured that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability
b. made each resident and their family aware of the complaints procedure as soon as is practicable after admission
c. ensured the resident has access to advocacy services for the purposes of making a complaint
d. displayed a copy of the complaints procedure in a prominent position in the designated centre

The registered provider has ensured that:
a. a person who is not involved in the matters that are the subject of complaint is nominated to deal with complaints by or on behalf of residents
b. all complaints are investigated promptly
c. complainants are assisted to understand the complaints procedure

d. the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process
e. any measures required for improvement in response to a complaint are put in place
f. the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint and any action taken on foot of a complaint and whether or not the resident was satisfied

The registered provider has nominated a person, other than the person nominated to deal with complaints in paragraph (2)(a), to be available to residents to ensure that:
a. all complaints are appropriately responded to
b. the person nominated to deal with complaints maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied

The registered provider has ensured that any resident who has made a complaint is not adversely affected by reason of the complaint having been made

In response to the area of non-compliance found under this Regulation 34(2) (f): The registered provider will review the log and update to reflect all complaints received to date
Completed 30-11-2018

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication: The provider has ensured that each adult has access to information provided in a format that is appropriate to their needs. In as much as is practicable, the provider has ensured that all communication supports and assistance have been put in place in line with the regulation 10 and each individuals will and preference.
Through the PCP process and clinical governance forums, the PIC has ensured that all staff are aware and are familiar with the communication supports of each individual in their care.
• All residents have communication Passports
• Picture schedule of activities are available to residents to support communication
• Lamh signs and communication cues are available in the individual residents Person Centered Plan
• Environments are set up in such a way that all forms of communication is supported and respected
• Written communication needs are also available in easy to read formats.
• Each Resident has access to TV, radio, internet and newspapers

In response to the area of non-compliance found under this Regulation 10(3)(b) the registered provider is continuing to source the requirement of the appropriate Speech

and language therapist through Agency to meet the needs of the residents
28-2-2019

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Registered Provider has ensured that the premises of the Designated Centre is designed and laid out to meet the aims and objectives of the service and the number of residents.
• Is of sound construction and kept in a good state of repair externally and internally
• Is clean and suitably decorated
• Cleaning charts are completed daily
• Maintenance is logged and completed when required
• Residents decorate their own rooms
• Infection control guidelines are in place.
• All equipment are serviced regularly by the manufacturer and recorded
• Equipment checklist are in place
• Assistive technology, aids and appliances is available to support and promote the capabilities of residents.
• The premises ground floor is wheelchair accessible
The registered provider has made provision for the matters set out in Schedule 6

In response to the area of non-compliance found under Regulation 17 (1) (b)

The registered provider is currently in consultation with Castleblayney Care in relation to the proposal to adjust the premises so that it meet the needs and requirements of all residents

29-3-2019

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The provider ensures that effective fire safety management systems are in place in the centre and adheres to and is guided by the following;
☐Safety Health & Welfare at Work Act 2005
☐Health & Safety Authority Guidance on Fire Prevention and Fire Safety.
☐Code of Practice for Fire Safety in New & Existing Community Dwelling Houses 2017
☐HSE Fire Safety and Risk Management Policies and Procedures

Schedule 5 - Risk Management Policy.

The centre has a Fire Policy, Fire Precautions and Emergency Evacuation Procedures in place which have been drawn up in consultation with the HSE Fire Officer and are
• Reviewed annually or sooner if required.
• Easy read emergency evacuation procedures are available for residents.
• Staffs receive fire training on an annual basis which incorporates evacuation procedures and the use of fire fighting equipment.
• The centre is equipped with suitable fire safety equipment, including a fire alarm system which are routinely checked and serviced according to safety requirements.
• Emergency lighting is in place to clearly identify means of escape.
• Fire safety checks are completed and recorded in the Fire Register, faults noted are reported immediately.
• The centre is well maintained, free from clutter with cleaning schedules in place.
• Electrical equipment is maintained in good working order, a night time safety check is completed to ensure all electrical appliances are switched off.
• Fire drills and evacuations are conducted regularly with residents and a staff, details is recorded in the Fire Register. Drills include night time simulation & minimum staffing.
• Each resident has a personal emergency evacuation plan in place which is reviewed on annual basis or more frequently if there is a change in need or circumstances.
• The provider has a schedule of audit in place which includes six monthly health & safety audits and regular fire checks completed by the external contractor.
• The centre has a health and safety risk management system in place which includes;
A safety statement which is reviewed annually,
A risk register which includes risk assessment for fire safety & electrical appliances.
The fire precautions & evacuation procedures.
Emergency plans in the event of major emergencies.

The person in charge ensures that;
• The procedures to be followed in the event of fire are displayed in a prominent place.
• Fire checks are conducted according to the Fire Register and records are maintained.
• Fire drills are conducted quarterly or more frequently if required, the learning is shared with both residents and staff and relevant fire safety information is updated if required.
• The staff training matrix is monitored on a monthly basis to ensure fire training is completed within the required timeframes.
• Each resident's personal emergency evacuation plan is reviewed at six monthly intervals or in the event of a change in need or circumstances.
• All identified risks within the centre are kept under review.
• The centre is well maintained, repairs and faults are promptly addressed and the centre is free from clutter ensuring escape routes are unobstructed.
• Cleaning schedules are completed.
• All staff adheres to the Risk Management Policy.
• All staff have read and signed the Health & Safety Statement.
• Fire safety is a standing agenda item on both staff and resident meetings.

In response to the area of non-compliance found under Regulation 28(4)(b)
The person in charge will carry out Fire drills at suitable regularly intervals, so staff and residents are aware of the procedure to be followed in case of a fire

Last fire evacuation carried out on the 11-12-2018 and are scheduled for monthly

Completed and ongoing on 11-12-2018

Regulation 7: Positive behavioural support	Not Compliant

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

The provider has the following measures in place to ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with schedule 5 policies, evidence based practice and are used as therapeutic interventions within a multi - disciplinary approach which is reflective of minimising harm and reducing injury.

• A Multidisciplinary team which includes Psychology,, Behaviour Therapy, Psychiatry, Physiotherapy and Occupational therapy.
• Registered Nurses trained in Intellectual Disability.
• Person Centred Care planning in place for each resident which is subject to a multidisciplinary review annually or should a change in need or circumstances arise.
• A schedule of mandatory staff training which includes Positive Behaviour Support and Safeguarding Awareness training in line with national policy.
• Regulatory notification to HIQA at the end of each quarter.
• A suite of policies and guidelines for staff which include;
□The Restrictive Practices Policy.
□Positive Behavioural Support Policy.
□Risk Management Escalation Policy
□Safeguarding Vulnerable Persons at Risk of Abuse.
□Open Disclosure

The person in charge ensures that where a resident's behaviour necessitates intervention under this regulation every effort is made to identify and alleviate the cause of the residents behaviour of concern, this includes;
• An individual assessment of need with a corresponding person centred plan which are subject to review.
• Referral to other departments as appropriate such as Psychology, Behaviour Therapy, and the Mental Health team to ensure all alternative measures are considered before a restrictive procedure is used; and the least restrictive procedure, for the shortest duration necessary, is used.
• Residents are provided with information on advocacy services, the Confidential Recipient, the Safeguarding Team, Complaints Officer and HIQA and are supported to access these services if they so choose.
• Staff have up to date knowledge and skills, appropriate to their role, to respond to

behaviours of concern and to support residents to manage their behaviour.
• Staff receive training including refresher training in the management of behaviour of concern including de-escalation and intervention techniques.
• Staff training records are monitored and training is maintained within the required time frames.
• Routine audits to ensure compliance with this regulation which includes the audit of ;
• accidents and incidents,
• complaints
• Resident's personal plans
• Administration of PRN Medication

In response to the area of non-compliance found under this regulation 7(1): The person in charge will ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. All staff attended training with the Senior Clinical Psychologist on the 15-11-2018 to discuss the residents' behaviour support plans.

Completed

In response to the area of non-compliance found under this regulation 7(4) The registered provider will ensure that , where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidences based practices.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The registered provider has ensured that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.
The registered provider ensures that each resident:
1) Participates in and consents, with support where necessary, to decisions about his or her care and support.
2) Has the freedom to exercise choice and control in his or her daily life
3) Can exercise his or her civil, political and legal rights
4) Has access to advocacy services and information about his or her rights
5) Is consulted and participates in the organisation of the designated centre

Resident meetings take place regularly and all residents have an opportunity to discuss any issues.
Advocacy is available if any residents would like to access them
All residents have a person centred plan in place and develop goals/aspirations that they would like to achieve.

The registered provider has ensured that each resident's privacy and dignity is respected in relation to his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information

All residents have their own bedroom and ensuite. Intimate care plans are in place within the residents' person centred plans.

In response to the area of non-compliance found under this regulation 9(3) The registered provider and the Person In Charge will ensure that invitations to meetings will only be extended to the resident and their requested family member

Completed on the 22-11-2018 and ongoing

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(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	28/02/2019
Regulation 10(3)(b)	The registered provider shall ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.	Substantially Compliant	Yellow	28/02/2019
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	Not Compliant	Orange	10/12/2018

	statement of purpose and the size and layout of the designated centre.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	29/03/2019
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	27/11/2018
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	Substantially Compliant	Yellow	11/12/2018

	procedure to be followed in the case of fire.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	31/01/2018
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	30/11/2018
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is	Not Compliant	Orange	15/11/2018

	challenging and to support residents to manage their behaviour.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	15/11/2018
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	15/11/2018
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care,	Not Compliant	Orange	22/11/2018

	professional consultations and personal information.			