Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Inis Grove Adult Residential Service
Name of provider:	RehabCare
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	30 November 2020
Centre ID:	OSV-0002645
Fieldwork ID:	MON-0030882

About the designated centre

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

Inis Grove Adult residential service provides a full-time residential service to a maximum of three adult residents. The provider states that it aims to ensure that the care and support provided is person-centred, delivered in conjunction with residents and their families in a home from home environment. Residents are assessed as needing a high level of care and support across a broad range of needs, but the model of care is described as primarily social. The staff team is comprised of care and social care staff supported and managed by the team leader under the direction and oversight of the person in charge.

The premises is a two storey property with facilities provided to residents on both floors. The premises is located on its own spacious site; the site includes a recreational area to the rear of the property.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 30 November 2020	09:45hrs to 17:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction of and onward transmission of COVID-19. The inspector met with one of the two residents living in this centre. This was influenced not only by the requirement for infection control measures but also by the needs and routines of the residents. For example one resident attends an off-site day service and has a morning routine prior to their departure. The inspector did not disturb this routine. Both residents also primarily communicate using non-verbal means but have good receptive skills. Though engagement with the inspector was brief this ability was evident. The inspector was introduced to the resident by staff and it was obvious from the residents relaxed demeanour that the resident was ok with the presence of the inspector. When asked how he was the resident replied good. The inspector enquired if the resident would like to show the inspector their preferred relaxation space and the resident went with the inspector to the room. The television was on and the programme was set to the resident's liking. When asked what it was they wanted to do for the remainder of the day the resident returned to the main hall and indicated the transport vehicle to communicate their wish to spend time out of the centre with staff. The inspector saw that the resident spent sometime in the rear recreational space prior to leaving the centre with staff. Neither resident had returned to the centre prior to the conclusion of this inspection.

Capacity and capability

This inspection was undertaken to follow-up on the unsatisfactory findings of a January 2020 inspection. In the intervening months the provider has been submitting as requested, six-weekly updates to the Health Information and Quality Authority (HIQA) on its improvement plan for this centre. This plan includes the relocation of this service to a new location; there has been some delay outside of the control of the provider, to this plan as a result of COVID-19 restrictions.

There was evidence of some improvement, for example there were less restrictive practices, evening staffing levels had been increased, fire safety systems had been reviewed and some repairs and refurbishment of the premises had been completed. However, overall these inspection findings did not provide assurance of governance systems that ensured effective management and oversight so that residents received an individualised, safe, high quality service. This finding was relevant to the management and oversight of this existing service but also raised concerns as to how relocation to the new service would achieve better outcomes for residents. The provider was not satisfactorily acting on information that was collated or made known to it so as to drive improvement, such as the findings and action plans from

inspections and internal reviews, the monitoring of incidents that occurred or feedback received on the service that was provided.

For example the inspector reviewed the findings of two recent internal reviews of the service completed by the provider itself. The findings of the first review undertaken in June 2020 indicated that the matters of non-compliance arising in this centre were escalated to a senior level within the organisation in line with the governance structure. However, the findings also indicated that the actions that had arisen from the January 2020 HIQA inspection were not all satisfactorily addressed, for example locked final exits, premises works and the number of restrictive interventions in use. The review found that further improvement was needed in each of these areas. The internal review also found that improvement was needed to the plans in place designed to support residents as they transitioned to the new service. One area highlighted by the reviewer was the failure of the plan to address the compatibility of residents' needs. It was of concern to this inspector given the findings of the June 2020 internal review, to find that the second internal review completed in mid November 2020 still found that more detailed and robust transition plans were needed. The inspector saw that the transition plans themselves did not address resident compatibility in any meaningful way. While the possible impact of this will be addressed in the next section of this HIQA report, it is of relevance here in the context of governance and the failure to follow through on actions designed to improve the quality and safety of current and planned services.

The most recent internal review also highlighted the significant number of recorded behaviour related incidents but no identified pattern and, the failure to escalate and substantiate the decision to suspend family visits in response to Level 5 COVID-19 restrictions. Again these matters will be discussed in detail in the next section of this report but collectively the findings described here are not reflective of an effectively managed and overseen service where action plans, risks, information and decisions are consistently monitored and reviewed, effectively and purposefully used so that residents at all times receive a safe, high-quality service. At verbal feedback of the inspection findings the provider was requested to review as a matter of priority the transition plans and the arrangements for facilitating or suspending family visits in response to COVID-19 restrictions. The requirement for a robust response to these inspection findings was also reiterated. The provider committed to address the failings in this service.

The provider had since the last HIQA inspection increased the evening staffing levels three evenings each week; this will also be discussed in the next section of this report in terms of not adequately demonstrating how this improved life for residents. There had been some turnover of staff since the last inspection but the inspector was advised that a recruitment campaign had been successful and some existing staff had also increased their baseline hours. The inspector reviewed a sample of current and planned staff rotas and saw that the staffing levels and arrangements were as described including the enhanced evening staffing levels. The same staff were listed on the rotas indicating that the consistency that residents needed was provided for.

The inspector reviewed records of training completed by staff. These records

reflected the staff listed on the rota and indicated that all mandatory, required and desired training was in date, for example, safeguarding, fire safety and medicines management. Additional training that reflected the assessed needs of the residents was also listed such as autism specific training. The training programme was responsive to change and all staff were listed as having completed infection prevention and control training including hand-hygiene, using personal protective equipment and COVID-19 specific training.

Regulation 15: Staffing

Staffing levels and arrangements were suited to the number and the assessed needs of the residents. There was a planned and actual staff rota that included management and frontline staff and the hours worked each day by each staff member.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a programme of baseline and refresher training and based on the records seen all training was up-to-date. The person in charge confirmed that newly recruited staff were completing mandatory training using on-line facilities as appropriate due to the constraints of COVID-19. There was a programme of staff supervision that was reported to be on schedule.

Judgment: Compliant

Regulation 23: Governance and management

Overall these inspection findings did not provide assurance of governance systems that ensured effective management and oversight so that residents received an individualised, safe, high quality service. This finding was relevant to the management and oversight of this existing service but also raised concerns as to how relocation to the new service would achieve better outcomes for residents. The provider was not satisfactorily acting on information that was collated or made known to it so as to drive improvement and provide residents with a better service. Action plans external and internal, risk assessments and known information such as incidents were not effectively monitored and reviewed and purposefully used to inform and reflect on how the service was operated. This did not ensure that residents at all times received a safe, high-quality service suited to their individual

needs.

Judgment: Not compliant

Quality and safety

As discussed in the first section of this report, these inspection findings did not provide assurance as to how the provider ensured and assured itself that it was providing each resident with the best possible support and service as applicable to their needs and associated risks.This lack of assurance extended to the planned relocation to the new centre as it was not evident how better outcomes for residents would be achieved if consideration of individuality, compatibility and risks was not integral to the planning of the new service. As stated at the time of the last HIQA inspection this was a particular concern given the lower age profile of these residents and the need to maximise opportunities and systems that kept them safe but also promoted their ongoing welfare and development. In addition it was not evidenced that the objective assessment of risk informed decisions that impacted on residents, decisions that had an adverse impact on their quality of life, such as the use of restrictive interventions and suspended access to family during COVID-19 restrictions.

The inspector reviewed one personal plan in detail and reviewed both transition plans; the latter were in place to support residents to manage change and successfully transition to their new home. The inspector saw that the baseline plan of support reflected the assessed needs as described by staff and was updated as needed so that the guidance in the plan reflected the input of members of the multi-disciplinary team (MDT). Narrative notes created by staff reflected the implementation of this guidance on a daily basis, for example efforts to reduce reliance on restrictive practices and promote sensory programmes. Feedback on the success or failure of these interventions was reported back to the relevant member of the MDT and a pattern of improvement was emerging. However, what was not adequately evidenced was how the review of the personal plan questioned and corrected as needed the appropriateness, suitability and effectiveness of the plan and of the support provided. For example how the plan and support could consistently maximise each residents capacity for personal and skills development when there were obstacles to therapeutic programmes such as restrictions designed to keep peers safe and unresolved triggers for behaviour that impacted on the implementation of the sensory programme. For example it was hoped to develop resident independence in household routines and tasks such as meals and mealtimes. Conversely the assessed needs of a peer meant that there was restricted access to certain foods and items. In addition there was no evidence in the plan of how additional staff resources were integrated in to the plan and used to improve residents routines, choices and quality of life.

This raised concerns that existing arrangements were not suited to individual needs

and the review of the transition plans raised concerns that relocation to the new service would continue rather than address this. Despite the differences between residents assessed needs and associated risks there was a generic tone to the plans and the plans did not establish how the plan was informed by individual needs and risks, by what was known not to work in the existing service and what clearly needed to change so that the transition would achieve better outcomes for each resident.The inspector saw that it was planned that three residents would live in the new service but as found by the June internal review, the transition plans did not address in any substantive and meaningful way, the compatibility of the assessed needs of the three residents. Words such as known to and familiar with were used but there was no objective assessment of compatibility and no reference to the incompatibility identified by this inspection. This did not provide assurance as to how the new service would be safe.

Having seen reference in records to behaviour related incidents that were increased and significant, the inspector requested to review the record of incidents and accidents that had occurred in the centre. Initially the inspector requested sight of records of the analysis of these incidents, analysis that would have been completed to identify information such as triggers, patterns, intensity, frequency and staff responses. The inspector was advised that each individual incident was reviewed by management and other stakeholders and discussed at staff meetings but there was no collective analysis as described and requested by the inspector. This was of concern as having reviewed a small sample of the regular and frequent behaviour related incidents that had occurred it was evident to the inspector that the behaviour of one resident was noted by staff to be a trigger for self injurious behaviour in response by their peer. At times the behaviour was directed at staff but it was generally directed at self and caused distress and harm. This trigger and impact on resident safety and quality of life was not referenced in any other record seen such as the transition plan and the risk assessments for both residents such as the risk for self-injurious behaviour and behaviour of risk towards others.

In general the inspector found that in addition to this reported lack of structured review, learning and change to improve both the safety and quality of the service, all decisions that impacted on residents life were not informed by the objective assessment and balancing of competing risks. This resulted in controls that were disproportionate and had an adverse impact on residents. Both residents enjoyed and benefited from regular contact with family, this contact was also important to their families. Staff confirmed however, and records seen reported that visits to and from family had been suspended in the context of COVID-19 restrictions. Staff described how alternatives had been trialled but were not that successful in the context of residents assessed needs. Records seen such as the monthly report provided to representatives documented the impact of this on residents, an impact that was expressed through behaviour of concern and risk to self and others including their peer who then exhibited behaviour in response. It was also clearly documented that when visits had been allowed, this had a positive impact on resident emotional and psychological well-being with reduced incidence of behaviours. It was evident that residents struggled to understand and cope with this loss of family contact. When visits were re-instated residents communicated that what was allowed was not fully meeting their needs, for example their observed

reluctance to leave family and return with staff. Representatives had also sought an extension of what was allowed. However, while motivated to protect residents and staff from the risk of COVID-19, staff confirmed that the decision to suspend visits was not informed by the objective assessment of the competing risks as provided for in national guidance, where such visits are important for the holistic well-being of the resident, in particular where the resident was exhibiting a rise in behaviours of distress. While visits had by the time of this inspection recommenced, the learning from the impact of suspended visits, from the feedback received from representatives and the dissatisfaction communicated by residents was not formally evident.

There was a requirement to keep residents safe and some controls designed to manage risks were classified as restrictive practices. There was a noted reduction in these practices since the last inspection and evidence of efforts informed by clinical input to reduce another. For example there was now no evident intrusion on residents privacy and personal space, the inspector saw that both residents had access to their personal toiletries and staff confirmed that 15 minute supervision checks had ceased at night-time while by day staff endeavoured to promote therapeutic engagement rather than standalone checks of residents. However, residents continued to be exposed to interventions that were deemed to be needed for the safety of their peer rather than any risk associated with their own assessed needs, that is locked external doors and restricted access to kitchen cupboards and certain foodstuffs. It was not evidenced how relocation to the new service would address this.

Notwithstanding the decision-making that informed the suspension and ongoing facilitation of visits, overall staff described infection prevention and control practice that was in line with national guidance. As discussed in the first section of this report staff had completed the relevant training modules, staff and resident well-being was assessed daily so as to detect any possible signs of COVID-19. Staff confirmed that they had access to adequate personal protective equipment and used a face- mask at all times. Residents were supported to complete hand-hygiene and one resident had good tolerance for wearing a face mask. The inspector saw that wash-hand basins had been supplied with soap and disposable paper towels, and there was ready access to hand sanitizing products. Staff reported that having these items prominently available had not created any challenges for residents. The person in charge continued to operate two staff teams, this reduced the crossover of staff and limited contacts in the event of suspected COVID-19. There was a contingency plan in the event that a staff or resident had suspected COVID-19.

Improvement was noted in fire safety systems. Staff confirmed that while exit-doors were still locked the number of keys needed to open these doors was reduced to two. The inspector saw that internal fire resistant doors had been repaired. Inspections of the fire detection and alarm system, the emergency lighting and fire-fighting equipment were all up-to-date. Three simulated evacuation drills had been completed since the last HIQA inspection and one of these was undertaken to simulate the night-time arrangements in the centre. However, all three drills had used the same escape route rather than rotating the route used, this routine could create challenges to evacuation in the context of residents assessed

needs.

Regulation 17: Premises

The inspector noted that repairs and refurbishments had been completed to improve the condition and presentation of the premises. Overall however, these premises present poorly and ultimately are not suited to the assessed needs and associated risks of the residents. For example the overall security of the site and facilitating access for all residents to all areas and facilities where there is no risk to the individual that would preclude such access.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was an absence of structured review and analysis of incidents that occurred in the centre and consequently an absence of evidence of learning and timely, corrective actions to improve both the quality and safety of residents lives. All decisions about the support that was provided, decisions that impacted on residents lives, were not informed by the objective assessment and balancing of competing risks. This resulted in controls that were disproportionate and had an adverse impact on residents. For example while motivated to protect residents and staff from the risk of COVID-19, staff confirmed that the decision to suspend family visits was not informed by the objective assessment of the competing risks as provided for in national guidance, where such visits were important for the holistic well-being of the resident, in particular where the resident was exhibiting a rise in behaviours of distress.

Judgment: Not compliant

Regulation 27: Protection against infection

Overall the practice observed and reported was consistent with national guidance designed to reduce the risk of the accidental introduction of and onward transmission of COVID-19. Staff described the controls in place including daily monitoring of well-being, enhanced environmental cleaning and the use of PPE. The inspector noted the improvement in hand-hygiene facilities.

Judgment: Compliant

Regulation 28: Fire precautions

Simulated evacuation drills had all used the same escape route rather than rotating the route used, this routine could create challenges to evacuation in the context of residents assessed needs.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

It was not adequately demonstrated in the personal plan and in the review of the plan how the arrangements in the centre were suited to the assessed needs of each resident and promoted their ongoing general and personal development. It was not evident in the plans for transition how relocating to the new service would promote better outcomes for residents by having arrangements and facilities that were suited to residents individually and collectively, for example in relation to the ongoing need for restrictive practices. The inspector saw that it was planned that three residents would live in the new service. However, as found by the internal review completed in June 2020, the transition plans did still not address in any substantive and meaningful way the compatibility of the assessed needs of the three residents. It was evident from these inspection findings that there were needs that were not compatible and had a negative impact on residents.

Judgment: Not compliant

Regulation 6: Health care

Staff reported that generally residents enjoyed good physical health and were facilitated to have access to the services and clinicians that they needed. For example from healthcare records and plans the inspector saw that residents had access as needed to their General Practitioner (GP), psychiatry, occupational therapy, behaviour support, dental services and other hospital based services. There was some delay in transferring from paediatric to adult services but the inspector was satisfied that appropriate clinical oversight was available and maintained during this transition.

Judgment: Compliant

Regulation 7: Positive behavioural support

On reviewing a small sample of the regular and frequent behaviour related incidents that had occurred in this centre, it was evident to the inspector that the behaviour of one resident was noted by staff to be a trigger for self- injurious behaviour in response by their peer. At times the behaviour was directed at staff but it was generally directed at self and caused distress and harm. This trigger and impact on resident safety and quality of life and how it was to be addressed, was not referenced in any other record seen such as the transition plan and the risk assessments for both residents such as the risk for self-injurious behaviour and behaviour of risk towards others. Residents suffered distress exhibited as behaviour of risk and harm as a consequence of suspended visits.

While there was a noted reduction in the number of restrictive interventions residents continued to be exposed to interventions that were deemed to be needed for the safety of their peer rather than any risk associated with their own assessed needs, that is locked external doors and restricted access to kitchen cupboards and certain foodstuffs. It was not evidenced how relocation to the new service would address this.

Judgment: Not compliant

Regulation 8: Protection

The person in charge confirmed that no safeguarding concerns had arisen since the last inspection. All staff had completed safeguarding training; newly recruited staff were completing training prior to commencing work in the centre. The matter of needs that were incompatible and that resulted in distress and harm is addressed in this report in the context of behaviour support, risk management, and the personal plan as the impact was not intentional and residents did not direct their behaviour at their peers.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	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	Compliant

Compliance Plan for Inis Grove Adult Residential Service OSV-0002645

Inspection ID: MON-0030882

Date of inspection: 30/11/2020

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 23: Governance and management	Not Compliant

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

• The PIC will upload all actions arising out of this Compliance Plan onto the organisation's Action Tracking Database, the PIC will provide updates on the system as actions are progressed and closed. The PPIM (ISM) will monitor progress and verify once actions are completed.

• The PIC and PPIM (ISM) will meet on a monthly basis to formally review progress of this compliance plan.

• The Quality & Governance Directorate will provide a report to the organisation's Senior Management Team and Board on a monthly basis in respect of actions linked to non-compliances in this action plan until all such actions are closed off.

• A copy of this Inspection Report has been provided to the organisation's Board of Management. The board will also be provided with ongoing updates in relation to actions, completed and outstanding.

• The PIC supported by the Team Leader and Behaviour Therapist will conduct a formal review of all incidents on a Monthly basis. The purpose of the review will be to identify trends and ensure appropriate corrective action are taken in a timely manner. Where required Risk Assessments and individual plans will be updated based on the findings of these reviews.

• The Behaviour Therapist will complete Compatibility Assessments of the proposed three residents for the new service. As part of this assessment the Behaviour Therapist has completed observations of all three proposed residents interacting in the day service together on December 9th 2020. Once completed this report will be reviewed by PIC and senior management the findings of the report will be used to inform how the

transition will progress in the first instance, the service review will be ongoing. It is expected that this process will be completed by the January 22nd 2021.

• The Behaviour Therapist has visited the new residence, findings from these visits will inform the compatibility assessment. The purpose of these visits was to inform support arrangements for the new house including the living/sleeping arrangements for residents and also to look at any potential requirements for Restrictive Practices.

• Each of the Resident's Assessment of need will be reviewed by service staff, Behaviour Therapist and family members. These Assessments of Need will be used to inform Transition Plans and Support Plans for each of the proposed Residents.

• Robust Transition Plans for each of the proposed Residents will be developed, these will include timeframes for completion of actions. The plans will include the following elements:

· Introducing residents to the new residence so that residents can become familiar with the new environment.
· Measures to ensure that the move to the new residence promotes a positive progressive plan to promote the quality of life of each of the residents.
· Use of All about me – user friendly profile of each resident and Moving House-social story adapted to inform residents of the move to the new house.
· Discussion with families to identify what is important for their loved one in their new home. Family members to be involved in choice of décor in bedroom, communal areas and items for the outside area.
· Actions to ensure items of importance are transferred to the new residence
· Support residents to have input regarding the décor of the new residence, including their bedrooms and communal areas. This would also be informed by the known preferences, likes and dislikes of residents, e.g. items of interest.
· Two of the proposed residents currently live together. The 3rd resident lives in their family home at present. All three proposed residents will be introduced through the day service in Shannon. This process commenced in late November.

• A report will be submitted to regulator by the January 29th 2021 in addition to the application to register the new service. This report will detail the progress made in the transition to the new residence, findings of the compatibility reports, plans to enhance the resident's quality of life through the move and updates on meeting compliance target dates outlined in this compliance plan.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The new residence has a gate and fence to the front of house. This will support resident's safety and promote independence.

• The move to the new residence will allow the provider more freedom in adapting the environment to suit the needs of the residents and also afford the residents security of tenancy.

• NF35 to be sent to HIQA by January 29th to notify the Provider's intent to cease operating the existing service.

• Application to Register the new service to be sent to HIQA by January 29th.

Regulation 26: Risk management procedures	Not Compliant

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

• Incident reports will be generated and available to inform decision making, copies of the national monthly incident report will be available in the service.

• The PIC supported by the Team Leader and Behaviour Therapist will conduct a formal review of all incidents on a Monthly basis. The purpose of the review will be to identify trends and ensure appropriate corrective action are taken in a timely manner. Where required Risk Assessments and individual plans will be updated based on the findings of these reviews. Individual incidents and a review of learning from incidents will continue at monthly staff meetings.

• All risk assessments will be reviewed monthly. PIC to consider all competing factors when analyzing risk, using all relevant information ensuring that the control measures are proportionate to the identified risk and that the impact on the residents quality of life is central to decisions taken. This include the PIC ensuring that all identified risks are assessed and documented on a risk assessment, reviewed as appropriate.

• On review of risk assessments, a summary of review of risk will be logged and filed in the Risk Management Framework.

• Going forward the PIC will escalate COVID19 specific risks to the provider's Case Management Team who will provide risk assessment and decision making support.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: An alternative escape route to be used for next fire drill, documented on fire drill report. Escape routes will be alternated on any further fire drills facilitated in the service.

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: • Behaviour Therapist and service staff will review residents current support plans, Behaviour Management Guideline's and Transition Plans. Once reviewed this information will used to enhance transition plans and develop support plans for the Residents within their new home. • The Behaviour Therapist will complete a Compatibility Assessments of the proposed three residents for the new service. As part of this assessment the Behaviour Therapist has completed observations of all three proposed residents interacting in the day service together on December 9th 2020. Once completed this report will be reviewed by PIC and senior management the findings of the report will be used to inform how the service will progress. It is expected that this process will be completed by January 29th 2021.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Behaviour Therapist and service staff will review residents current support plans, Behaviour Management Guideline's and Transition Plans. Once reviewed this information will used to enhance transition plans and develop support plans for the Residents within their new home. • The PIC supported by the Team Leader and Behaviour Therapist will conduct a formal review of all behaviour related incidents on a Monthly basis. The purpose of the review will be to identify trends and ensure appropriate corrective action are taken in a timely manner. Where required Risk Assessments and individual plans will be updated based on the findings of these reviews. Impact on the quality of life of residents will be central to any decisions taken. • Individual behavioural incidents including a review of learning will continue at monthly

staff meetings. In addition there will be weekly review and analysis of incidents by Team Leader through weekly audit.

• The Behaviour Therapist has visited the residence, findings from these visits will inform the compatibility assessment including the potential requirements for any Restrictive Practices. Recommendations will also be provided in terms of support arrangements for the new residence including the living/sleeping arrangements for residents. Once completed this report will be reviewed by PIC and senior management the findings of the report will be used to inform how the service will progress. It is expected that this process will be completed by January 29th 2021.

• Review of current RP's was completed on December 9th 2020.

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	29/01/2021
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	29/01/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of	Not Compliant	Orange	22/01/2021

	Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	22/01/2021
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	22/01/2021
Regulation 05(2)	The registered	Not Compliant	Orange	29/01/2021

	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).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	29/01/2021
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	29/01/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Not Compliant	Orange	29/01/2021

	this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			