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:	Sylvan Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Short Notice Announced
Date of inspection:	21 October 2020
Centre ID:	OSV-0001485
Fieldwork ID:	MON-0030228

About the designated centre

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

Sylvan Services consists of two houses and provides residential and respite services for up to nine male and female residents aged over 18 years. Residents have a diagnosis of intellectual disability, some with various support needs, ranging from moderate to high, and some include co-morbidity. The houses are centrally located in a large city in the west of Ireland and close to amenities such as shops, restaurants, public transport, pharmacists and churches. The houses are comfortably furnished, have gardens, and each resident has their own bedroom. Residents are supported by staff teams which include the person in charge, a team leader, social care workers and care assistants. Three residents are supported on a 1:1 staff basis and the remainder of residents receive close supervision in the centre. There are waking staff in both houses at night. Day staff support residents from home with meaningful activities due to the Covid 19 pandemic.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Wednesday 21 October 2020	10:00hrs to 17:00hrs	Thelma O'Neill	Lead

What residents told us and what inspectors observed

The designated centre consisted of two houses. which were located in Galway city. On the day of inspection, there were five residents in one house and two residents in the other house. The inspector only visited the house where the five residents reside on this occasion. In this house, four residents reside full-time, and three residents received respite in the centre. The inspector was also informed that one of the respite residents had chosen to stay at home with their families during the COVID-19 public health crisis, and had not as yet returned to the centre.

Due to the COVID-19 pandemic, the inspector met with residents and staff while adhering to public health guidance in relation to face masks and physical distancing. Residents were given the opportunity to speak to the inspector, however, they choose not to. Staff told the inspector that residents spent time baking, gardening, and table top activities in the centre.

The inspector met with the four residents briefly on arrival to the centre in the morning. Four of the residents were being supported by two day staff in the centre, another resident at the centre attended a day centre due to their complex needs. During the day, the four residents went for a drive and a walk to local park area, and staff told the inspector that residents really enjoyed going out of the house and going for a walk in the forest. The inspector also observed residents watching television and painting pictures with the support of staff.

One resident was being supported by staff on the day of inspection to redecorate their bedroom and staff said the resident was excited about this activity. The inspector also met another resident on their return from day services in the evening. The resident was not able to communicate verbally with the inspector, however, they communicated through sign language.

The inspector observed the residents being well supervised by the staff and most of the residents appeared to be happy communicating with each other in the centre.

Capacity and capability

This inspection was conducted as a risk inspection following a serious incident occurring in the centre. The inspector found that significant improvements were required in the management of this service. Some of the non-compliance identified at this inspection had already been identified by the person in charge, notwithstanding this, considerable improvements were required to ensure that the provider was meeting the requirements of the regulations.

The inspector found this centre was was not meeting the care and support needs of the residents, all of the regulations reviewed, required improvement. This was found in relation to risks identified in areas of Individual assessments and personal plan, Protection, Managing behaviours of concern, Risk management, Staffing, Complaints procedure, Notifications of incidents, Training and staff development, Governance and management, Residents rights, and Protection against infection. Each of these issues will be discussed in further detail throughout the report.

The provider's governance and management arrangements at the centre had not ensured compliance with the regulations, and ensured arrangements at the centre met residents assessed needs and kept them safe.The inspector saw clear evidence of this when an emergency situation occurred in the centre the night before the inspection. The relief staff member received no answer to their calls for help, consequently, the staff member had to call the emergency services for support. The person in charge told the inspector that there was no response to the staff's calls for help, as is no actual on call support arrangements in place in Ability West from 5pm to 9am each evening/night from Monday evening until Friday morning. This incident showed the lack of governance and oversight by the provider regarding the need for out of hours on call arrangements to support staff working in the centre out of hours.

This inspection was conducted as a risk inspection following a report that a serious accident had occurred in the centre. Initially, The Health Information and Quality Authority (HIQA) issued a provider assurance report to the provider, seeking assurances that the risks identified had been addressed, and that appropriate safety measures had been put in place in relation to risk management and positive behaviour support. Written assurances were received from the provider that these issues were reviewed and actions were put in place to manage the risks. However, during the inspection, the actions identified had not been fully completed. Prior to this serious incident occurring in the centre there were indications in the annual review that the quality and safety of care and support in the centre was a serious concern, as the report showed that there were 124 incidents (excluding covid 19 notifications) in the past year. However, 92 of these incidents of various degrees of risk related to behaviours of concern in the centre, but the annual review did not identify these risks in the action plan. In addition, the annual review had not been approved by the provider representative, providing no confirmation that these issues were reviewed by any member of the senior management team.

Furthermore, an external unannounced audit was completed on the 2nd July 2020 by the provider. The audit reviewed 23 regulations and all regulations were deemed compliant, with two regulations substantially compliant by the provider's representative. While the audit did acknowledge there were safeguarding concerns and residents were unsuitably placed in the centre, no action plan was put in place to address these identified issues. Furthermore, the provider's audit action plan did not identify who was responsible for addressing those actions identified or the time-scale in which the actions would be completed. On review of these actions, the inspector found that actions identified in the action plan had not been addressed on

the day of inspection.

The person in charge advised the inspector that the staffing arrangements in the centre had changed since the COVID-19 pandemic began. Some residents were assessed as requiring 1:1 supervision during the day, but at night the staff ratio fell to 1:5 leading to issues of risks in the centre. The staffing level at night required review as one of the residents that frequently displayed behaviours of concern and had complex medical issues, was not closely supervised at night. This was a concern, due to the size of the house and the night staff could not observe or hear the resident mobilising upstairs. While an alarm mat was put in place at the resident's bedroom door, the risks associated with the resident's staffing need was not appropriately considered in terms of the current staffing support needs at night.

There was a staff training record maintained in the centre, which detailed training programmes for staff as part of their continuous professional development programme. On the day of the inspection a training day scheduled for three staff on the safe administration of medication was cancelled unexpectedly. On review of the staff training many of the staff working in the centre did not have up to date refresher training completed in a large number of areas, for example;

Three staff were out of date in the protection of vulnerable adults,
Two staff were out of date in manual handling,
Five staff were out of date on training for epilepsy and administration of emergency medication.
Eight staff were also out of date in training for diabetes management, in particular the safe administration of insulin.
Training in mental health illness for all staff was an action identified following a serious incident that occurring in the centre, but this has not yet happened.

Furthermore, the person in charge confirmed to the inspector that she had difficulty in securing training for staffing in some of these areas, due to COVID 19, but this issue was not identified on the centre risk register or identified on the provider audit as an issue.

The registered provider failed to ensure the complaints procedure was effective to support residents when they made an a complaint. The inspector found one resident had made two complaints regarding safeguarding risks. In the complaint, the resident expressed their fears and discontent at the behaviours exhibited by one of their peers in the centre, and they described in the complaint the impact this behaviour was having on them. While the complaint was reported to the safeguarding officer and senior manager, no preliminary screening was completed, and the complaints were not investigated. The management of complaints was also an action identified on the last inspection that was not addressed.

The person in charge did not notify the chief inspector within three days of adverse incidents occurring in the centre as required by the regulations. for example, there were several incidents reported in the incident records where there were unexplained absences of a resident from the designated centre, and incidents of allegation of suspected or confirmed abuse between peers that were not notified

to the Chief Inspector as per regulatory requirements.

Regulation 15: Staffing

Night time staffing arrangements did not reflect the assessed care and support needs of the residents in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had not ensured that staff received up-to-date training in a number of areas; for example, three staff were out of date in the protection of vulnerable adults, three staff were out of date in fire safety training, and eight staff were out of date in training for diabetes management, in particular the safe administration of insulin.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and management arrangements at the centre did not ensure residents were kept safe and their assessed needs were met, leading to a negative impact on their quality of life and personal rights.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge did not notify the chief inspector within three days of adverse incidents occurring in the centre as required by the regulations. for example, there were several incidents reported in the incident records where there were unexplained absences of a resident from the designated centre, and incidents of allegation of suspected or confirmed abuse between peers that were not notified to the Chief Inspector as per regulatory requirements.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider failed to put an effective complaints procedure in place in this centre. Several complaints made by residents about not been happy or feeling safe in the centre were closed and not investigated. Residents were not assisted to fully understand the complaints procedure or offered an advocate to support them making a complaint.

Judgment: Not compliant

Quality and safety

The inspector found that significant improvements were required in the quality and safety of care provided to residents in this centre. Several serious risk and safeguarding incidents had occurred in the centre that had impacted negatively on residents' safety and quality of life. The provider was aware of these ongoing risks in the centre, some going back several years, but had failed to adequately address these issues.

A review of the residents' individual assessment and personal plans showed some residents were not suitability placed in this centre. The premise and the associated environment was identified as one of the key issues that were negatively impacting on resident's behaviour, and as a result, many restrictive practices were in place to manage risks associated with residents' behaviours of concern. Consequently these behaviours and restrictions were impacting on all of the residents in the centre, but the there was no strategic plan in place to rectify these issues.

The provider had policies and procedures in place to manage risks in the centre. However, on review the inspector found that risks associated with certain residents were not appropriately assessed or managed. For example, a resident known as a high risk for absconding (who's bedroom was upstairs in the centre) had jumped out their bedroom window and fell to the ground outside the centre. A post incident review, resulted in window restrictions being placed on all of the windows in the centre, however, the provider failed to identify how this impacted on other residents. Also a review of the resident's individual risk assessment showed that the identified risk of falls and absconding was rated a low risk, even though records showed that the resident continued to make attempts to leave the house unsupervised.

Some residents displayed frequent behaviours of concern, such as shouting for long periods of time in the centre, banging doors and disturbing other residents, entering

other residents bedroom without permission, and exhibiting inappropriate behaviours towards others, which frequently resulted in vulnerable residents being advised by staff to leave communal rooms if they did not feel safe. The provider did not ensure that resident's displaying inappropriate sexual behaviours were provided with the appropriate education to improve their self awareness of their behaviour and its impact on others. In addition, the inspector found some residents did not have behaviour support plans updated by a suitability qualified person to manage behaviours of concern in the centre.

There were active safeguarding risks in the centre, that were negatively impacting on all residents safety and privacy. One resident had reported these safeguarding concerns to the person in charge. A review of incident records showed that these safeguarding incidents continued to occur regularly, however, no preliminary screening had been completed following incidents occurring in the centre, and some residents at risk, did not have active safeguarding plans in place and one residents that did have a safeguarding plan, it was not updated to reflect their risks.

A review of residents' individual risks identified two residents with a risk of choking. Safety measures to keep these residents safe from choking, resulted in strict environmental restrictions on their access to food in the house, for example kitchen food cupboards, the fridge and utility cupboard where food was stored were all locked. While these restrictions were used to prevent these residents from choking or consuming inappropriate food, the measures negatively impacted on the rights, choice and dignity of all residents in the centre, and in addition had not been subject to review on their appropriateness by the provider's restrictive practice or the human rights committees.

The provider had protocols in place for the management and prevention of an outbreak of COVID-19 cases in the centre; including the appropriate use of PPE daily temperature checks for staff and an enhanced cleaning schedule. However, there was no centre specific contingency plan in place to manage an outbreak of COVID-19 in the centre if it occurred. This was a concern, as the person in charge had completed a COVID-19 risk assessment for each resident and identified that none of the residents would self-isolate in their bedroom in the event of being exposed to COVID-19. In addition, two respite residents were admitted to the centre each week from home, and no specific infection control measures or contingency plan was in place to manage the infection risks posed to these residents, or the existing residents in the centre.

Residents freedom to exercise choice and control in their daily life, was limited in this centre as they were living with restrictions put in place to manage their peers' safety risks. There was no evidence that any resident was advised to access advocacy services and information about their rights, including their privacy and dignity.

Regulation 26: Risk management procedures

Centre specific and residents' individual risks were not clearly assessed and managed. For example, residents' behaviours of concern, safeguarding and infection control. In addition, where risks had been identified they were not appropriately risk rated, for example, a resident whose repeated absconding from the centre had on one occasion resulted in a fall from an upstairs bedroom window, had this rated as a low risk.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had systems in place for the identification and prevention of COVID-19 in the centre; including availability of PPE, staff training, and an enhanced cleaning schedule. However, the inspector found that there were no centre or resident specific infection control measures or written contingency plan in place for the centre in the event of an outbreak of COVID-19.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' individual assessments were completed, however, residents care and support needs were not updated to reflect the current support needs, and no action plans were put in place to address these needs. There were two residents that were identified as not having their needs adequately met in this centre. However, there was no updated plans or transition plan in place to address these issues.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had not put an appropriate plans or reviews in place to adequately assess the impact of all of the restrictive practices used in the centre on the residents. Furthermore, the provider did not ensure that residents were supported to develop self awareness of their behaviour and its impacts on others.
Restrictive practices in use in the centre were not reviewed by the human rights committee or the restrictive practice committee.

Judgment: Not compliant

Regulation 8: Protection

The provider failed to respond to safeguarding incidents that were identified in the centre. Preliminary screenings had not been completed and safeguarding plans were not updated following safeguarding incidents in the centre as the provider's policy. Furthermore, two staff were out-of-date in training in the safeguarding of vulnerable adults.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' rights and dignity were not protected in this centre. Some residents' privacy and dignity was not respected as their personal space, was invaded by other residents. In addition, freedom around their home was limited due to restrictions placed on them or their peers to manage behaviours of concern. In addition, residents were not provided with independent advocacy services and information about their rights in the centre.

Judgment: Not 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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sylvan Services OSV-0001485

Inspection ID: MON-0030228

Date of inspection: 21/10/2020

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of the assessment of needs for each resident has been completed by the PIC on 24 November 2020. A staffing needs analysis for nighttime for all residents was completed and this identified that the current roster provides appropriate staffing levels at nighttime to meet residents' needs. Following this analysis, an auditing tool has been implemented by the Person in Charge (PIC) and Person Participating in Management (PPIM) and this will be reviewed on a monthly basis. The PIC and PPIM will review the results of the detail from these audits and will adjust rosters and staffing ratios accordingly. The restrictive practice in place for a nighttime alert has been reviewed and a protocol has been developed to record, monitor and review this restriction, this restriction has been approved by the Restrictive Practice Committee.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All outstanding training has been completed. Diabetic refresher training was completed on 16th November 2020. Safeguarding Vulnerable training for adults was completed by 21st November 2020. Fire Safety training was completed on the 15th November 2020.	

Manual handling training was completed on 26th November 2020.

Complaints training was completed by 26th November 2020.The training matrix has been updated accordingly by the PIC on the 27th November 2020.

The training matrix will be reviewed at monthly staff meetings, led by the PIC. A training needs analysis has been completed by the PIC, to assess if current staff training provides the skills required to meet resident's needs. This will be reviewed on a monthly basis by the PIC and should additional service user specific training be identified, the PIC and PPIM will ensure training is carried out within the current month that it is identified.

Staff support and development meetings between the staff team and the PIC are up to date. A schedule of staff support and development meetings is in place and there will be a focus on staff training for at these meetings.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC and PPIM have scheduled weekly Support and Supervision meetings which have commenced on 6th November 2020 and will continue into 2021, these meetings have a structured agenda to include the issues highlighted in this inspection. This will include a review of action plans from inspections and audits to ensure adherence to timelines and to evaluate the effectiveness of action outcomes.

At organisational level, a process has been developed for oversight on progress of actions plans, with involvement from the Client services and Quality and Compliance Department, this process will commenced 11th November 2020 and continue on a monthly basis.

A local on call arrangement has been put in place for weekdays, clearly informing staff who they can contact between 5pm and 8am in the event of an emergency. Organisational management on-call arrangements from Monday to Friday is under review by the HR department for discussion with the Senior Management Team. The first report was discussed on 25th November 2020, with next meeting due to take place on 16th December.

All staff have completed additional training by 26th November 2020 in complaints and Safeguarding Vulnerable Adults was completed by 21st November, policies and procedures relating to these areas will be a standing agenda item at monthly staff meetings. The PIC will ensure that residents are supported to access user friendly documents including the right to feel safe and information regarding advocacy services. This will continue to be addressed at house meetings and reviews will take place on a

monthly basis to determine effectiveness and if required, advice from Speech and Language will be sought.

From a Governance and Management perspective the PIC has completed additional training in the identification of risk, and the completion of service risk assessments. This was completed on 19th November 2020. The Centre risk register has been reviewed and updated and includes incompatibility issues related to a resident in the service. This risk has been escalated to the senior management team on 27th November 2020.

The PIC and the Designated Officer have reviewed all Safeguarding Plans. All Staff have completed training in Safeguarding Vulnerable Adults at risk of Abuse by 21st November 2020. Residents will be supported to access user-friendly documentation, the right to be safe and identified documentation. The Speech and Language Department will be accessed to support and promote resident's knowledge. Weekly review of the incident reporting system by the PIC will take place to identify trends relating to safeguarding, also to identify potential safeguarding concerns. The outcomes of these reviews will be discussed at the scheduled PIC and PPIM meetings, staff meetings, residents house meetings and escalated to Senior Management Team as required.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A review of all logged incidents has taken place on 19th November 2020, additionally the review will continue at the weekly scheduled PIC /PPIM meetings. This process will ensure that all incidents are reported including notification of incidents to HIQA.
Staff have been informed that all incidents must be notified to the PIC who will then complete necessary actions and notifications where required.

A review of the incidents on QMIS and Notifications will be audited by the PIC on a monthly basis to identify and inform the service requirements of the residents in this service.

Following the identification of unreported notifications in quarter 1 2020, the required notifications have been completed and submitted to the Chief Inspector by the PIC on the 11th November 2020.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All staff have undertaken Complaints training by 26th November 2020. This will be a standing agenda item at monthly team meetings going forward and will also continue to be discussed at Residents weekly house meetings. The service has accessed resident friendly complaints information. Each keyworker will support the residents to make complaints should they wish to do so.

The PIC and the PPIM will review complaints as they occur at their scheduled meetings. Advocacy Service supports are also available to residents and this information is visible within the centre. This information will also be circulated to all families/guardians.

Complaints information will be reviewed at the scheduled case reviews which family members attend, information on complaints process will be re-circulated to all families/guardians.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The designated centre has been reviewed by the PIC and PPIM on 19 November 2020 in terms of risks and the risk register updated accordingly to ensure all centre risks are identified appropriately. These risks include absconding, behaviours that challenge, use if restrictive practices, resident's rights and safeguarding.

A review of restrictive practices by the PIC was completed on 16 November 2020. This review highlighted that a number of restrictions in place impacted on other residents in the house. A referral to the Human Rights Committee relating to the impact on others of these restrictions was submitted on 7 November 2020 and this referral has been added to the agenda for the meeting on 7 December 2020.

A local on-call arrangement has been put in place for weekdays, clearly informing staff who they can contact between 5pm and 8am in the event of an emergency.
Organisational management on-call arrangements from Monday to Friday is under review by the Human Resource department for discussion with the Senior Management Team. The first report was discussed on 25th November 2020, with next meeting due to take place on 16 December 2020.

The centre specific Covid 19 contingency plan has been updated by the PIC and PPIM, this includes a review of all resident's self-isolation assessments and contingency plans for a suspected or confirmed case of Covid 19.

The Covid 19 protocols for infection control measures for residents and respite service

users have been reviewed the PIC and adhere to the public health guidelines in place at this time.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The centre specific Covid 19 contingency plan has been updated by the PIC and PPIM, this includes a review of all resident's self-isolation assessments and contingency plans for a suspected of confirmed case of Covid 19.

The PIC and staff team attended a HIQA Webinar on 2 November 2020, this webinar was titled 'National Standards for Infection prevention and control in community services: Putting the standards into practice'

The PIC ensures that self-declaration forms are completed prior to respite break, this ascertains the Covid 19 status of the respite service and their household prior to the respite break. In the event of any concerns being raised in the completion of the self-declaration form, the respite break is cancelled.

The PIC ensures that the importance of adhering to infection control measures is highlighted to the residents at weekly resident meetings.

All staff have completed mandatory Covid 19 training regarding Hand Hygiene, Donning and Doffing of PPE in community settings and Infection control in Community Settings. The training matrix has been updated to include the dates of this training

Risks pertaining to healthcare associated infections and Covid 19 are included in the centre risk register and mitigating safety measures included.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All assessment of needs have been reviewed and updated by the PIC and PPIM. They now reflect the current support needs of the residents. One resident's assessment of need has highlighted the necessity for a change of living environment for one of the

residents and plans have been formulated to proceed with a transition to a more suitable service. It is planned to be completed by January 31st, 2021. Assessment of need forms will be reviewed on an annual basis or more frequently if required.

A review of individualised Positive Behavior Support plans and Psychological and Behavioral support guidelines has been undertaken by the PIC and relevant Multi-Disciplinary Team professionals on 11th November 2020.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Restrictive practices have been referred to the relevant rights committee in the organisation for review and approval.

The PIC has undertaken an environmental Restrictive Practice review on 18 November 2020 has taken place and a further external one will be completed on 1 December 2020.

A review of restrictive practices by the PIC was completed on 16 November 2020. This review highlighted that a number of restrictions in place impacted on other residents in the house. A referral to the Human Rights Committee relating to the impact on others of these restrictions was submitted on 7 November 2020 and this referral has been added to the agenda for the meeting on 7 December 2020.

Restrictive practices will continue to be a topic at the weekly resident's house meetings. User friendly supports will be utilised to support this. The purpose of these meetings will be to develop resident's self-awareness of their own behaviour and its impact on others, support from members of the multi-disciplinary will be utilised as appropriate.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Designated Officer and the PIC reviewed safeguarding plans on 18 November 2020 and a cover note has been applied to each plan to provide updates and actions to be applied if further concerns arise. An annual review form of closed safeguarding plans to the DO and the HSE but remain active in the service has been put in place and this will assist the PIC and staff team to ensure the safeguarding plan is adhered to and that any

new concerns are referred to the Designated Officer as appropriate.

A review of all logged incidents has taken place on 19 November 2020, additionally the review will continue at the weekly Scheduled PIC and PPIM meetings. This process will ensure that all incidents are reported including notification of incidents to HIQA.

The review of logged incidents and the HIQA report has highlighted a number of incidents that required notification to the Chief Inspector. Whilst these incidences were reported to the Designated Officer and dealt with through the complaints process, the Chief Inspector was not notified at the time, NF06's have been submitted on 11 November 2020.

Staff have completed training in Safeguarding Vulnerable Adults at risk of abuse by 21 November 2020 Residents will be supported to access user-friendly documentation, the right to be safe and identified documentation. The Speech and Language Department has been requested to support and promote resident's knowledge. Weekly review of the incident reporting system will take place to identify trends relating to safeguarding, also to identify potential safeguarding concerns. The outcomes of these reviews will be discussed at the scheduled PIC and PPIM meetings, staff meetings, Residents House meetings and escalated to Senior Management as required.

Safeguarding will be a standing agenda item at the monthly staff team meeting.
The 'Right to feel safe' will continue to be reviewed at the resident's weekly house meetings. Key workers will discuss this topic at 1:1 meetings with residents in a manner appropriate to their level of understanding.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Resident's rights will be promoted through weekly house meetings, keyworker meetings, annual case reviews.
A review of residents expressed choices and rights will be audited following discussion with residents, family members, and key workers. Documentation review will be based on house meetings, daily log notes, family contact logs and communication book.

A number of restrictions have been reviewed and deemed appropriate by the Restrictive Practice Committee. A Planned environmental restrictive review will be carried out by an external PIC on 1 December 2020 to ensure the least restrictive environment possible.

Restrictions which have been forwarded to the Restrictive Practice Committee will be reviewed at the 7 December 2020 meeting.

Restrictive practices will continue to be discussed at team and house meetings.
The Independent Advocacy Service has been contacted, additional information will be

made available to residents, Speech and Language Department have been requested to provide User friendly documentation on 27 November 2020 and will be utilised as required.

Safeguarding plans are in place and staff will continue to be vigilant in terms of adhering to these plans to ensure safety of all residents
Restrictive Practices will continue to be a topic at the weekly residents house meetings. User friendly supports will be utilised to support this, the purpose of these meetings will be to develop resident's self-awareness of their own behaviour and its impact on others, support from members of the multi-disciplinary will be utilised as appropriate.

A review of restrictive practices was completed by the PIC on 16 November 2020. This review highlighted that a number of restrictions in place, impact on other residents in the house. A referral to the Human Rights Committee relating to the impact on others of these restrictions was submitted on 7 November 2020 and this referral has been added to the agenda for the meeting on 7 December 2020. The PIC and PPIM will implement any recommendations arising from this meeting.

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 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	27/11/2020
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.	Not Compliant	Orange	27/11/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	31/12/2020

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	30/11/2020
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/11/2020
Regulation 31(1)(e)	The person in charge shall give the chief inspector notice in writing within 3 working days of the	Not Compliant	Orange	11/11/2020

	following adverse incidents occurring in the designated centre: any unexplained absence of a resident from the designated centre.			
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.	Not Compliant	Orange	11/11/2020
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	27/11/2020
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Not Compliant	Orange	27/11/2020
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).	Substantially Compliant	Yellow	31/01/2021

Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/11/2020
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	27/11/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	18/11/2020
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	18/11/2020
Regulation 09(2)(b)	The registered provider shall ensure that each	Not Compliant	Orange	30/11/2020

	resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			