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:	Cavan Supported Accommodation
Name of provider:	RehabCare
Address of centre:	Cavan
Type of inspection:	Short Notice Announced
Date of inspection:	01 October 2020
Centre ID:	OSV-0002676
Fieldwork ID:	MON-0030221

About the designated centre

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

Cavan Supported Accommodation provides a community-based residential service for up to seven adults with mild to moderate intellectual disabilities. The centre is located in a busy town in Co Cavan. Residents have access to amenities such as shops, cafes and restaurants. Cavan Accommodation comprises three self-contained apartments. Apartment one has three bedrooms, two bathrooms, a shared kitchen and living area and a staffroom. Apartment two and three both have two bedrooms, each with a shared bathroom, kitchen and living room area. Residents are supported on a 24-hour basis by a team of support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Thursday 1 October 2020	10:00hrs to 16:00hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

The inspector visited one of the three apartments that made up the designated centre. The apartment was well maintained and the residents' bedrooms had been decorated to their preferred tastes. Residents were observed to be active in their home and particpating in short activities outside of the centre with the support of staff.

The inspector met with two of the residents in their kitchen area. The residents spoke about their plans for that evening and that they were happy to be back attending their day service, even though it was only for two days a week. The residents expressed that they were happy in their home and chatted with the inspector about some of their frustrations regarding restrictions implemented due to the COVID-19 pandemic.

The residents appeared comfortable in their home and spoke positively about the staff team supporting them.

Capacity and capability

The provider's capacity and capability to provide the highest standard of care and support was affected by inadequate leadership, governance and management arrangements, and staffing deficits.

The centre's management team was made up of a person in charge and a team leader. The person in charge was responsible for three other services that were being delivered by the provider and had a limited presence and oversight of the service. The person in charge was supported by a team leader who was completing additional shifts and duties due to staffing deficits. This requirement was further impacting on the monitoring and oversight of the service.

There was a need to review and address the staffing resource in the centre. Staffing arrangements were not always appropriate to meet the needs of residents, and this had an impact on the residents' quality of life. The impact will be discussed in more detail in section two of the report. The inspector reviewed the centre's roster and noted that there was a consistent staff team supporting those living in the centre. The staff team consisted of a team leader and support workers. The inspector reviewed information which showed that prior to and during the COVID-19 pandemic, the centre was receiving additional staffing hours of thirty-five hours per week in order to support the needs of residents. A review of a sample of residents' information demonstrated that the needs of some residents had recently increased. Despite this, the additional supports that had been in place during the early phases

of the COVID-19 outbreak had been greatly reduced since late July to fourteen hours per week.

The centre's roster displayed that only one staff member was responsible for meeting the needs of all residents from evening to morning time each day and for the majority of the day at the weekend. The provider had supplied an extra staff member for two hours per day at weekends to support residents to leave their home for walks or home visits. There was evidence of the staff team seeking to best support the residents, but the current number of staff supporting residents was no longer appropriate due to the changing needs of residents. The inspector reviewed correspondence between the person in charge and the provider's senior management team and noted that while requests for additional supports were being made and that there was a planned meeting with the Health Service Executive to review funding for additional support hours for the centre, the lack of a suitable level of staffing remained an issue.

While the provider had ensured that the 2019 annual review of the quality and safety of care and support had been carried out as per the regulations, the review had failed to identify the areas that required improvement and had had not ensured that the service being provided was consistent and effectively monitored.
The centre had been visited by a person nominated by the provider in July of this year to review the safety and quality of care and support provided in the centre. A written report completed following the visit captured the high level of improvements required. The report had clearly outlined the required advances, but many of the improvements had not been addressed. The provider had failed to ensure that there were appropriate systems in place to address the findings from the report.

During the course of the inspection, it was noted that some records and assessments were not easily accessible and in some cases were not up to date or had not been completed. For example, the person in charge had failed to ensure that the required quarterly notifications, as listed in the regulations, were being submitted for review by the Chief Inspector. There were further improvements required to ensure that the staff team were receiving appropriate supports and that the residents' contracts for the provision of services were up to date.

The provider had schedules in place to supply appropriate training to staff. Despite this, there were improvements required to guarantee that all staff members were completing refresher training, including the management of behaviour that is challenging, when required. The provider had, however, been proactive in ensuring that the staff team had completed infection, prevention and control training in response to COVID-19.

Supervision was being provided by the centre's team leader. A review of records demonstrated that there were improvements required to ensure that staff members were receiving appropriate supervision and support. There was evidence of supervision taking place, but the frequency of the supervision for all staff members was not in line with the provider's own policies and procedures.

A sample of residents' contracts of care were reviewed by the inspector. While the provider had ensured that these had been developed, the contracts required updating as they no longer accurately reflected the fees residents were paying for rent.

Overall, it was found that there was an absence of effective and responsive management systems to ensure that residents were receiving a safe and consistent service. The oversight and auditing of practices being carried out in the centre required review.

Regulation 15: Staffing

The provider had failed to ensure that staffing levels were appropriate to the number and assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had not ensured that there were appropriate arrangements in place for training and staff development.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management arrangements did not ensure that the service being provided was appropriate to the needs of all residents.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had failed to ensure that residents' contracts for the provision of services were suitably maintained.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had failed to submit the necessary quarterly notifications for review by the Chief Inspector as per the regulations.

Judgment: Not compliant

Quality and safety

The inspector found that there were systems in place to promote positive outcomes for residents. Nonetheless, the current staffing deficits and management practices impacted the provider's ability to meet the needs of all residents effectively. Further issues were identified with the upkeep and auditing of documentation relating to individual assessments, risk management, and positive behavior support.

A sample of residents' assessments and personal plans were reviewed by the inspector. While the review found that assessments of residents' health, personal and social care needs had been carried out, the inspector was not assured that the centre was adequately resourced and organised.

As noted in section one of the report, there were periods each day where staffing levels in the centre were reduced to just one member of staff, this also included days during the weekend. A review of records showed that one resident had recently sustained falls over a weekend resulting in the resident receiving medical attention. Occupational therapy assessments carried out following these incidents outlined that the resident required supervision when mobilising. However, the staffing levels at specific periods meant that this was not manageable and could impact on the service being provided to the remaining residents. Staff members spoken to during the inspection expressed that it was challenging to support all residents during evening and weekend periods and was impacting on their ability to complete all assigned tasks each day. The staffing deficits were also impacting residents' engagement in activities outside the centre in the evenings and at weekends, as residents required support and there were not enough staff to allow this.

The person in charge and staff team had focused on developing the functional and daily living skills of residents and these support plans were under regular review. There were appropriate healthcare assessments in place and residents were being supported to access allied healthcare professionals, including mental health supports, when required. However, while there were clear documentation and auditing practices in place for some residents, this practice was not consistent,

resulting in some residents' information not being maintained appropriately. For example, some residents documents were not available for review or had not been updated to reflect their current needs.

While there was evidence of goals being developed for residents, a review of these goals demonstrated that residents were not being supported to achieve them. For some residents, goals had been set with no further documentation or evidence of progress being made towards achieving these goals. Other residents had not been supported to review their goals since June 2019. In some cases, the information failed to outline the supports required to assist residents with their personal development in accordance with their needs and wishes.

The inspector reviewed the centre's risk management practices and found that there were improvements required. There was a risk register in place that assessed the social and environmental risks present in the centre. The inspector found that the risk register had not been updated since February 2019. A number of the residents' risk assessments were not up to date and did not accurately reflect the supports residents required. The inspector reviewed other residents' risk assessments and found them to be detailed and under regular review. The provider had also ensured that there was a risk management policy that had been reviewed appropriately and contained the necessary information as per the regulations. There were also arrangements in place for the identification, recording, and learning from serious or adverse events.

The provider had failed to ensure that all members of the staff team had completed the required refresher training in the management of behaviour that is challenging. The provider's most recent audit identified that a resident's behaviour support plan required updating. The inspector found that this support plan had not been subject to regular review, with the existing support plan being in place since 2011. While there was evidence of the team leader seeking guidance from the provider’s behaviour support specialist, there were improvements required to the documentation of this guidance to ensure that all staff members could access the information for review.

The provider and the person in charge had adopted procedures consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority. The COVID-19 risk assessments developed for residents, the staff team, and visitors were detailed and developed according to the Health Protection Surveillance Centre (HPSC) guidelines.

The provider had ensured that there were systems in place to safeguard residents adequately. There was evidence of residents being assisted and supported to develop the knowledge, self-awareness, understanding, and skills needed for self-care and protection. Residents were being provided with the information through residents' meetings. A further review of these meetings demonstrated that residents were being kept up to date with information regarding COVID-19 and the impact that this was having on practices in the centre. Resident meetings were also

providing residents with information in regard to the provider's complaints procedures.

Overall, there were improvements required to ensure that the centre was appropriately resourced to meet the needs of all residents. There were further improvements required to areas including individual assessments, management of residents person-centered goals, behaviour support practices, and risk management. There was evidence of the staff team responding to the changing needs of residents, but the existing monitoring practices were not ensuring that all residents' assessments were being monitored effectively. This was, impacting on the quality and safety of care being provided to residents.

Regulation 10: Communication

Residents were being assisted and supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 26: Risk management procedures

There was attention required to ensure that all aspects of the provider's risk management procedures were appropriate.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider and the person in charge had adopted procedures consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was attention required to ensure that residents' individual assessments were effectively monitored. There were further improvements required in the monitoring and progression of residents' goals.

Judgment: Not compliant

Regulation 6: Health care

The provider had ensured that the residents were receiving or being offered appropriate healthcare.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had not ensured that all staff members had received appropriate training to respond to behaviour that is challenging. There were further improvements required to the documentation of input from the provider's behaviour support specialist.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were being supported to develop the knowledge, self awareness, understanding and skills needed for self-care and protection.

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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cavan Supported Accommodation OSV-0002676

Inspection ID: MON-0030221

Date of inspection: 01/10/2020

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Prior to Covid-19, in February 2020, the Provider had engaged in initial discussions with the HSE around a review of service user needs and staffing requirements in the supported accommodation service. During the initial period of Covid-19 the Provider's Day Service Staff were redeployed to the Supported Accommodation providing an enhanced staffing compliment to support the needs of service users. • Since the Inspection the Provider has implemented an additional 63 hours Support Worker hours per week with the aim of ensuring the health, safety and well-being of service users on an interim emergency basis. For consistency of supports to service users the core team and relief support workers are doing additional hours to meet this need (However, this measure will require approval from the funder for it to be an on-going support to service users). • A review of the staffing needs for the service based on the needs of service users has now been completed by Rehab Group Senior Management in conjunction with the PIC. This was completed by the 07/10/2020. • Rehab Group Senior Management have had a meeting with the funder on the 13/10/2020 and it was agreed that a Business Case be completed and submitted to the HSE for approval in order to staff the service to meet the assessed needs of service users. • Pending approval of the Business Case by the funder additional staffing will be implemented on an on-going basis to meet the needs of service users. • Should additional staffing not be approved by the funder to support the assessed needs of service users, the Provider will support individuals with additional needs to seek appropriate alternative placements. • All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 30/11/2020 and two monthly periodic validation of compliance actions will take place going forward. This	

system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 16: Training and staff development	Substantially Compliant

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

• Two staff members had outstanding training requirements for MAPA refresher training at the time inspection. These has now been completed as of the 20/10/2020.
• The PIC has implemented a training calendar to identify where staff are required to engage in refresher training going forward.
• As part of the Monthly PIC audit the PIC will audit staff training records. This will ensure the timely completion of refresher training by all staff on an on-going basis. This has commenced from the 16/10/2020 and will be on-going each month.
• In response to Covid-19 Rehab Group have moved all mandatory staff training to an on-line portal to ensure the on-going training, development and upskilling of staff during the pandemic.
• All of the staff team have been facilitated to have a supervision session within the last three months in line with organisational policy.
• A schedule of quarterly supervisions has been developed in the service by the PIC and Team Leader. This has been completed by the 20/10/2020.
• Compliance with the schedule of supervisions will be maintained through the monthly PIC audit and this will be validated by the ISM.
• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 30/11/2020 and two monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 23: Governance and management	Not Compliant

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

• The PIC is on the Rota and present in the service two days per weekly 9 am to 5 pm, on other days the PIC is available for support on site.

• The Business Case which will be submitted to the funder encompasses a request for funding to recruit a dedicated PIC in order to address the governance and management of the service at a local level.
• The PIC has a monthly audit schedule developed for the service. This commenced as of the 16/10/2020. The PIC will now complete the local Monthly Audit of all key processes in the service as per the organizational documentation framework.
• The PIC has implemented a monthly schedule with the Team Leader who will complete the monthly team leader audits as per the organizational documentation framework.
• The organizational documentation framework will be implemented in the service by the PIC, Team Leader and support workers with support from the Integrated Services Manager. This will be completed by the 30/12/2020. The organizational documentation framework is aligned to the regulations as set out in SI 366 and SI 367.
• A scheduled weekly meeting is taking place between the Team Leader, PIC and Integrated Services Manager (PPIM) to monitor progress of this compliance plan. This weekly meeting will continue until all of the actions outlined in this compliance plan are closed. This commenced the 07/10/2020.
• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 30/11/2020 and two monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.
• A copy of this Inspection report has been provided to members of the Provider's Board.
• A monthly report will be supplied to the organisation's Senior Leadership Team and Board on progress of all actions arising out of non-compliances in this report, this will continue until all actions are closed.

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

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• All residents have their residents guide documents updated to include weekly rent charge. These have been discussed with residents and they have signed off to indicate that they understand and are happy with same. This was completed by 16/10/2020. The residents guide is formatted in an easy read document. This is reviewed annually with all service users by staff members to ensure their understanding of same.
• The PIC has supported service users to access the RehabGroup internal advocacy service (NRAC) or an external advocate where required. The Regional Advocacy Service

Lead will attend a residents meeting to refresh them of their role by the 30/11/2020.
• Each resident will have their contracts of care reviewed on at least an annual basis by the PIC. The providers tool for completion of the 6 monthly monitoring visit will be update to reflect that all contracts are reviewed on an at least annual basis.
• All service users/their representative will be met individually to have their contracts discussed with them so that they have a clear understanding of their contracts of care.
• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 30/11/2020 and two monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Notifications have now been submitted covering 2019 and 2020 to date with 3rd & 4th quarterly notifications scheduled for October 31st 2020 and January 31st 2021. This process will continue in 2021. This was completed by 09/10/2020.
• The PIC will attend a refresher HIQA training with the Senior Project Executive to ensure that they are clear on the Notifications required on an on-going basis.
• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 30/11/2020 and two monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.
• The Senior Project Executive will notify all PIC's on an on-going basis of the requirement to complete quarterly, 6 monthly, and annual notifications as outlined in the regulations.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Each Resident's Risk assessment have been reviewed and updated where appropriate to ensure they reflect the supports required by each resident. This was completed by 20/10/2020.
• All risk assessments will be reviewed as needs change going forward and will ensure that the recommendations made by MDT are included where relevant.
• The Risk Register for the service was reviewed on 21/10/2020.
• As part of the providers 6 monthly unannounced inspection the risk register for the service will be reviewed to ensure future compliancy with this regulation.
• The PIC will review the risk register when completing the monthly audit of the service to ensure on-going and regular updates to the risk register as required. This commenced as of the 16/10/2020.
• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 30/11/2020 and two monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

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:
• Since the Inspection the Provider immediately agreed to implement an additional 63 hours Support Worker hours per week with the aim of ensuring the health, safety and well-being of service users on an interim emergency basis. For consistency of supports to service users the core team and relief support workers are doing additional hours to meet this need (However, this needs approval from the funder for this to be an on-going support to service users).
• Each resident's individual needs assessment has been reviewed and updated. This was completed by the 20/10/2020.
• The service users support plans are in the process of being reviewed to ensure they reflect current needs and all required documentation is in place. As part of the overall review of support plans each resident will be supported to review their goals and new action plans will be developed in line with the resident's wishes. The progress of these actions will be reviewed as part of the local service monthly PIC audit. This will be completed by 30/11/2020.
• A meeting took place with the HSE Community Nursing Team on the 21/10/2020 to address additional support needs for one service user. This service user is being referred to Advocacy services externally for supports around their decision making in relation the

outcome of this meeting. An in-depth needs assessment will be carried out in conjunction with the HSE Community Nursing Team for this service user. A date is yet to be confirmed.
• The staff team will receive training in relation to the on-going completion of service user assessments, support plans, risk assessments in line with the organizational Service User Pathway. The staff team will receive training in relation to person centered planning/SRV. This will be completed by the 31/12/2020.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The Behavioral Therapist has reviewed all of the behavioral support plans that required review. This was completed as of the 20/10/2020.
• The PIC/Team Leader has scheduled quarterly prompts to engage the Behavioral Therapist to review and update plans as appropriate. The PIC will ensure that plans are reviewed and updated at a minimum annually.
• The Behavioral Support Therapist has provided a report to support the business case to the funder to increase staffing levels based on service user's needs.
• The Behavioral Therapist will attend at team meeting in order to support the team to implement the recommendations as outlined in the reviewed plans.
• All staff have completed MAPA training.
• The PIC will review training on a monthly basis as part of the PIC monthly audit schedule. This has commenced as of the 16/10/2020.
• All compliance actions will be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 30/11/2020 and two monthly periodic validation of compliance actions will take place going forward. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

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.	Not Compliant	Red	13/11/2020
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.	Substantially Compliant	Yellow	20/10/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	16/10/2020

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	Red	31/12/2020
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	16/10/2020
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.	Substantially Compliant	Yellow	21/10/2020
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at	Not Compliant	Orange	09/10/2020

	the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2020
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.	Substantially Compliant	Yellow	31/12/2020
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Substantially Compliant	Yellow	20/10/2020

	to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			