Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Suaimhneas
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	27 and 28 February 2019
Centre ID:	OSV-0001749
Fieldwork ID:	MON-0020892

About the designated centre

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

Suaimhneas provides residential care and support to two male residents with a disability and additional complex health and behaviour support needs. One resident attends a day service Monday to Friday and the second resident receives an individualised service facilitated by staff at the centre. The residents require a high staff support ratio due to their assessed needs associated with behaviours of concern. There is 24 hour nursing care provided at the centre as well as three staff members on duty during the day and two at night to support residents' needs. Residents are supported to engage in community activities and there are sufficient resources available to facilitate residents to achieve their social goals.

The following information outlines some additional data on this centre.

Current registration end date:	17/01/2021
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
27 February 2019	16:30hrs to 19:00hrs	Thelma O'Neill	Lead
28 February 2019	10:30hrs to 18:00hrs	Thelma O'Neill	Lead

Views of people who use the service

The inspector met both residents over the course of the two days of inspection. The inspector observed one resident interacting with staff in the kitchen while they were enjoying a cup of tea. The inspector observed the second resident from an distance, however, observations and interactions was limited with the resident due to risk management procedures being implemented while the inspector was present.

As the residents were not able to verbally communicate with the inspector, the inspector spoke with seven staff supporting the residents over the two days of the inspection. They were very knowledgeable about the residents likes and dislikes and the care and supports plans in place for the residents to ensure their health and well-being.

Capacity and capability

The inspector found that residents living at the centre had very complex health and behaviour support needs and received individualised and person centred care in the centre. However, the capacity and capability of the provider to support the residents complex physical and mental health needs were not adequately assessed in light of the current level of behaviours of concern being demonstrated in the centre; which resulted in frequent injuries to both residents and staff.

The inspector found that the person in charge had the skills, experience and qualifications to manage the centre. However, the person in charge was employed as a director of services by the provider and was directly responsible as a person in charge for seven other designated centres which impacted on the effectiveness of governance and management oversight at the centre.

Although the person in charge was supported in their role by a clinical nurse, they did not have an regular presence in the centre to ensure effective governance, operational management and administration of the designated centre on a day-to-day basis.

The inspector reviewed the actions from the last inspection and found that three outstanding issues were not addressed. Remedial works on the premise had not been completed, and the premise was not in a good state of repair. In addition, fire containment risks remained a concern, and this had first been identified on inspection in 2014. While the fire risks were a serious concern, the inspector was

satisfied that the provider had taken measures to mitigate the immediate fire risks with the high staff ratio in place over the 24-hour period, and daily fire safety checks were in place.

The staff team were very dedicated to the residents care needs. However, due to the level of restrictive practices in use in the centre, the inspector found there was a lack of support and supervision for staff due to the weak management structure and absence of multidisciplinary supports. For example, the behaviour support specialist post was vacant since 2017, despite a significant increase in the level of risk in the centre.

The provider had completed six monthly unannounced audits, and an annual review of the care and support provided at the centre. The audits further identified the outstanding building remedial and fire works required at the centre, and recorded that the provider's intention was to complete all outstanding works once the residents had moved to their new house. However, there was no time frame identified, as to when the new premise would be available.

Weekly meetings were held with residents and staff at the centre. These meetings provided staff with an opportunity to discuss areas such as activity planning, meal planning and any other topics of interests to the residents. In addition, a complaint register was maintained by the person in charge to record residents' views on the care and support provided, however, no complaints had been received to date at the centre.

The inspector found that appropriate number of skilled mix was in place at the centre to meet residents' assessed needs in a timely manner. Support and supervision meeting were held for staff by the clinical nurse manager regularly.

Regulation 14: Persons in charge

The person in charge had the skills, experience and qualifications to manage the centre. However, he did not have an regular presence in the centre, to ensure effective governance, operational management and administration of the designated centre on a day-to-day basis.

Judgment: Substantially compliant

Regulation 15: Staffing

The provider's staffing arrangements ensured that residents' assessed needs were meet in a timely manner, with high staff-to-resident support levels and access

to nursing staff.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had arrangements in place which ensured that staff had regular access to mandatory training to meet both the assessed needs of residents and regulatory requirements. However, staff did not have access to training in implementing physical restraint procedures currently in use on a daily basis in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management of this centre required review to ensure that the there was consistent oversight of the service and to ensure the provider was meeting the aims and objectives of the service, and the care and support needs of the residents. Furthermore, the provider failed to adequately address the actions from the last inspection in relation to premise, fire safety issues and the relocation of the service to a more suitable environment.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed accidents and incidents reports maintained by the provider and found that the Chief Inspector had been informed of such events in-line with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

A complaints register was maintained at the centre, however no complaints had been received to date.

Judgment: Compliant

Quality and safety

This centre provided residential care and support to two male residents with autism and complex health and behavioural support needs. The staff team were very committed to the care and welfare of the residents and had a very positive attitude towards meeting their needs. The provider had arrangements in place to safeguard residents and their assessed needs and this was clearly demonstrated through individual assessments and personal plans. However, the provider had not ensured that actions previously identified in other inspections had been addressed within agreed time frames and the significant risks relating to behaviours of concern were not appropriately managed.

The centre provided intensive support for two residents with complex behavioural support needs. Due to behaviours of concern, a range of restrictive practices were used, which included physical, environmental, mechanical and chemical restraints. The inspector found that although residents had behaviour support plans, these did not include clear guidance to staff on when, how and why restrictive practices should be used. Furthermore, the provider had not ensured that staff had received up-to-date training on the use of restrictive practices such as physical restraint. The provider had also not ensured that regular multi-disciplinary reviews had taken place to identify the type and frequency and suitability of the restrictive practices in use in the centre.

The residents received 24 hour nursing care and they had access to a range of allied health professionals to support their healthcare needs. Medication management was managed by the nurses on duty and the actions from the last inspection were addressed. However, the inspector found that an assessment into the suitability of the service to meet one of the resident's physical and mental healthcare needs had not taken place. In addition; the inspector found that while the residents had access to their GP services, there was an absence of a emergency medical plan to support residents when accidents or injuries occurred.

This centre is a two-storey dwelling which required significant structural and decorative remedial works to comply with the regulations. This issue was initially identified in 2014 and in all subsequent inspections and was still not addressed by the provider.

The provider had fire safety management plan and fire equipment in place to ensure that residents could evacuate safely in the event of a fire. However, Inspectors identified in 2014, fire risks in relation to the premises and a fire risk assessment conducted by an authorised fire expert in 2016 also identified that fire doors in the centre required upgrading and the utility room also required renovation works. However, the provider had not completed these works to date.

The inspector found that social care support provided to residents was to a good standard. The inspector reviewed residents' social care plans and activity records, and found that resources were available to enable them to participate in activities both at the centre and in the local community if they wished too.

The provider ensured that residents were protected from harm thorough the implementation of safeguarding arrangements.There was an up-to-date safeguarding policy in place and all staff had received 'safeguarding of vulnerable adults' training, which ensured that residents were treated with respect and dignity at all times.There were no safeguarding concerns reported at the centre at the time of inspection.

Regulation 13: General welfare and development

The provider had arrangements in place for residents to access facilities for recreation in accordance with their interests, capacities and developmental needs. The residents were also supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Judgment: Compliant

Regulation 17: Premises

The inspector found the action from the previous inspection were not completed. The centre required significant renovations and decorative works. Paintwork to walls throughout the centre were found to be in a poor condition. The inspector found the floor coverings throughout the house were marked and damaged.

Judgment: Not compliant

Regulation 26: Risk management procedures

Robust and effective risk management arrangements were in place, with an up-to-date risk register maintained in the centre. Risk were identified, analysed and control measures implemented to reduce any possible harm to residents.

Judgment: Compliant

Regulation 28: Fire precautions

There were fire containment risks remaining in the centre as identified in a fire risk report by an authorised fire expert in 2016. The report identified that all of the fire doors in the house required replacing and the utility room required additional renovation works to make it fire safe. These works were not completed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were safe medication management practices in the centre and there was an up-to-date policy to guide staff. Residents' medication was securely stored at the centre, and staff who administered medication had received training in safe administration of medication.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Individual assessments of the residents health and social care needs were completed, but, due to significant levels of incidents occurring in the centre, both to the residents and staff, there was a failure by the provider to assess the suitability of this service for the residents complex mental health and behaviour support needs.

Judgment: Not compliant

Regulation 6: Health care

The inspector found that while the residents had access to their GP services, the provider failed to implement an emergency plan to support the residents when they occurred, which had led to admissions to the emergency department for treatment which was distressing for the residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that there was not clear protocols in place for all restrictive practices used, in particular, physical restraint. For example, there was also no external review of the management of restrictive practices in the centre to ensure that the restrictions used in the centre were appropriate, timely and only used when required as per national guidelines.

Judgment: Not compliant

Regulation 8: Protection

The provider ensured the inspector that there were no safeguarding risks to residents in the centre. They demonstrated that there were clear arrangements for the reporting and investigating of safeguarding concerns and access to training ensured that staff knowledge and practices were up-to-date.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Suaimhneas OSV-0001749

Inspection ID: MON-0020892

Date of inspection: 27 and 28/02/2019

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.

"This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations."

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The provider ensures that: > A person in charge is appointed to the centre and that she/he is a fit person in line with HIQA's guidance on fitness. > All information required under schedule 2 of the regulations in respect of the person in charge is in place. >The person in charge is knowledgeable about the requirements of the Health Act 2007, regulations and standards. >The person in charge promotes person-centred care through a rights-based approach and is familiar with the residents' needs and ensures that they are met. >The person in charge effectively governs and manages the centre to ensure the delivery of a quality service in line with the centre's statement of purpose. >The person in charge ensures that through a programme of continuous professional development the staff team are suitably trained and have the skills to deliver a quality, safe service that is person centred. >The person in charge ensures that through effective communication and supervision the staff team are skilled, motivated and committed to providing care and support in a kind and compassionate manner that respects and protects the rights. privacy, dignity and choice of each resident. >The person in charge ensures that residents are supported to live meaningful and fulfilling lives in line with their needs and wishes and are actively involved in the day to day running of the centre. >An ethos of continuous quality improvement is embedded in the practices of the centre. Regulatory compliance is assessed and monitored using a self audit tool and corresponding quality improvement plan to address deficits and drive quality improvement initiatives.	

>Appropriate action is taken in a timely manner to ensure the centre maintains regulatory compliance.
> The provider visits and reports required under regulation 23 are completed to ensure the ongoing governance of the centre.

In response to the area of non-compliance found under regulation 14:
The Provider has ensured that arrangements have been made to restructure the governance within this centre. On the 12/03/2019 paperwork was submitted to HIQA via the portal to change the PIC to the CNM who is currently based within the centre. Awaiting new registration certificate for same. This will ensure effective governance, operational management and administration of the designated centre on a day-to-day basis.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The person in charge ensures that:
> Staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.
> A training need analysis is conducted annually which informs the training plan for the incoming year.
> A staff training matrix is in place to manage and monitor staff training to ensure training and refreshers are completed within the required timeframes; the person in charge reviews and updates the training matrix on a monthly basis.
>There is a schedule in place to complete ongoing formal supervision with staff
> The following information is made available to staff working in the centre;
• 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
• National Standards for Residential Services for Children and Adults with Disabilities,
• HIQA Assessment-of-centres-DCD_Guidance
• HIQA Assessment-Judgment-Framework-DCD_Guidance
• HIQA Enhanced-Authority-Monitoring-Approach Guidance
• HIQA Monitoring-Notification-Handbook-DCD_Guidance
• HIQA Statement-of-Purpose-for-designated-centres-for-Disabilities(DCD)_Guidance
Other relevant guidance issued by statutory and professional bodies

In response to the area of non-compliance found under regulation 16:
The Person in Charge has ensured that all staff within this designated centre have completed a 2 day training course in 'Professional Management Aggression and Violence'.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider ensures that:
>The centre is resourced to provide effective delivery of care and support in accordance with the statement of purpose. >There is a clearly defined management structure in place that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.
>Management systems are in place to ensure that the service provided in the centre is safe, appropriate to residents' needs, consistent and effectively monitored.
This includes;
• A schedule to ensure that an annual review of the quality and safety of care and support and six monthly unannounced visits of the centre are conducted, residents are consulted with as part of this process. •
Reports produced include plans to address any concerns regarding the standard of care and support provided. The reports are made available to the residents and their representatives.
• In response to HIQA's Enhanced Monitoring Approach, a framework for persons in charge to assess the centre's compliance with the regulations was introduced as a quality improvement initiative in March 2018, this is completed quarterly.
• A corresponding quality improvement plan is developed to manage and monitor any actions that arise.
• A schedule of audit is completed throughout the year to ensure the service provided is consistent and effectively monitored.
• An annual review and update of the centre's Statement of Purpose.
>To support staff exercise their personal and professional responsibility for the quality and safety of services they deliver and facilitate staff to raise concerns about the quality and safety of care and support provided to residents, the provider has the following measures in place:
• Formal supervision is completed with staff on a six monthly basis.
• Staff meetings are convened monthly.
• Mangers meetings are held fortnightly and minutes are made available in the centre to share information and learning.
• A suite of evidenced based policies are provided to guide and support staff.
• A health and safety management system which includes the corporate, organisational and centre specific safety statements, the risk register for the centre and the plans in place to respond to emergencies that may arise.
• A programme of mandatory training and a prospectus of professional development courses available through the Centre for Education.
• Staff are also supported to undertake training and development which is specifically relevant to the needs of the residents in the centre.

In response to the area of non-compliance found under regulation 23:
The Provider has ensured that a new suitable accommodation has been identified for the individuals within this designated centre. The transition will take place within quarter 4 of 2019. This will close out on the outstanding actions.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider ensures that;
> The premises of the centre meet the aims and objectives of the service and the number and needs of the residents in accordance with the centre's Statement of Purpose.
> A review of the premises forms part of the Annual Review of Quality and Safety of Care and Support and the six monthly unannounced visits of the centre to ensure that the premises is accessible, maintained in a good state of repair, is clean and suitably decorated and meets the needs of the residents.
>A quality improvement plan is produced to address any improvement required.
The person in charge ensures that;
> Actions identified by HIQA and/or the Provider Representative are included in the centre's quality improvement plan and monitored to ensure completed within the required time frame.
> All repairs are completed promptly and equipment is maintained in good working order.
>Referrals are made to the Assistive Technology department when required.
> Cleaning schedules are in place and implemented by staff.
>Infection control policies are adhered to.
> All identified risks are assessed and control measures put in place to manage the risk.> Environmental audits are completed as part of an annual schedule of audit.

In response to the area of non-compliance found under regulation 17:
The Provider and the Person in Charge has ensured that a new suitable accommodation has been identified for the individuals within this designated centre. The transition will take place within quarter 4 of 2019. This will close out on the outstanding actions.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The provider ensures that;
>Effective fire safety management systems are in place in the centre and adheres to and is guided by the following;
*Safety Health & Welfare at Work Act 2005
*Health & Safety Authority Guidance on Fire Prevention and Fire Safety.
*Code of Practice for Fire Safety in New & Existing Community Dwelling Houses 2017
*HSE Fire Safety and Risk Management Policies and Procedures
*Schedule 5- Risk Management & Emergency Planning Policy.
> The centre has a Fire Safety Statement, Fire Precautions and Emergency Evacuation Procedures in place which have been drawn up in consultation with the HSE Fire Officer and Estates Department and are reviewed annually or sooner if required.
> Easy read emergency evacuation procedures are available for residents.
>Staff receive fire training on an annual basis which incorporates evacuation procedures and the use of firefighting equipment.
> The centre is equipped with suitable fire safety equipment, including a fire alarm system which are routinely checked and serviced according to safety requirements.
> Emergency lighting is in place to clearly identify means of escape.
> Fire safety checks are completed and recorded in the Fire Register, faults noted are

reported immediately.
>The centre is well maintained, free from clutter with cleaning schedules in place.
>Electrical equipment is maintained in good working order, a night time safety check is completed to ensure all electrical appliances are switched off.
>Fire drills and evacuations are conducted monthly with residents and staff, details are recorded in the Fire Register. Drills include night time simulation & minimum staffing.
>Each resident has a personal emergency evacuation plan in place which is reviewed on a six monthly basis or more frequently if there is a change in need or circumstances.
>The provider has a schedule of audit in place which includes audit of fire safety and health & safety.
>The centre has a health and safety risk management system in place which includes;
* A safety statement which is reviewed annually,
* A risk register which includes risk assessments for fire safety & electrical appliances.
* The fire precautions & evacuation procedures.
* Emergency plans in the event of major emergencies.
The person in charge ensures that;
> The procedures to be followed in the event of fire are displayed in a prominent place.
> Fire checks are conducted according to the Fire Register and records are maintained.
> Fire drills are conducted monthly, the learning is shared with both residents and staff and relevant fire safety information is updated if required.
> Random questionnaires are completed with staff to consolidate knowledge of fire procedures.
> Fire safety audits are completed on a quarterly basis.
>The staff training matrix is monitored on a monthly basis to ensure fire training is completed within the required timeframes.
> Each resident's personal emergency evacuation plan is reviewed at six monthly intervals or in the event of a change in need or circumstances.
> All identified risks within the centre are kept under review.
>The centre is well maintained, repairs and faults are promptly addressed and the centre is free from clutter ensuring escape routes are unobstructed.
>Cleaning schedules are completed.
>All staff adhere to the Risk Management & Emergency Planning Policy.
>All staff have read and signed the Health & Safety Risk Management system.
>Fire safety is a standing agenda item on both staff and resident meetings.

In response to the area of non-compliance found under regulation 28:
The Provider and the Person in Charge has ensured that a new suitable accommodation has been identified for the individuals within this designated centre. The transition will take place within quarter 4 of 2019. This will close out on the outstanding actions.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The provider ensures that:
>The centre is suitable for the purposes of meeting the assessed needs of each resident and, where reasonably practicable, arrangements are in place to meet these needs.

> A Comprehensive system for the assessment and planning of each residents needs is in place which is conducted with the maximum participation of the resident and /or their representative.
The person in charge ensures that;
>Each resident has a personal plan, prepared no later than 28 days after admission to the centre, which reflects the resident's assessed needs and outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.
> All residents have a comprehensive assessment of need completed and a personal plan developed with the maximum participation of the resident and his/her representative where appropriate.
> The personal plan reflects the resident's needs and outlines the supports required to maximize the residents' personal development in accordance with the residents' wishes.
>Personal plans are made available to residents in an accessible format. > Individual support plans are evaluated on a quarterly basis or more frequently should the need arise.
> Personal plans are subject to a multidisciplinary review annually or more frequently if there is a change in need of circumstances.
>The review is conducted with the maximum participation of the resident and where appropriates his/her representative.
>The review assesses the effectiveness of the plan, takes into account changes in circumstances and new developments.
>Recommendations from the review are recorded and include:
· any proposed changes to the personal plan
· the rationale for any such proposal changes
· and the names of those responsible for pursuing objectives in the plan within agreed timescales

In response to the area of non-compliance found under regulation 5:
• The Provider has ensured that the resident has been assessed by an external Consultant Psychologist and an external Behaviour Therapist in relation to the suitability of the service to support the resident with their complex mental health and behaviour support needs.
• Findings from assessments have identified the requirement for a safe suitable placement and support required.
• The resident is currently residing in mental health services pending assessments through external agencies to meet the needs of this resident.
• Currently all personal plans are reviewed annually or as needs change with residents.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The provider ensures that:
>Appropriate healthcare is made available for each resident, having regard to that resident's personal plan. > When a resident requires services provided by allied health professionals, access to such services is provided The person in charge ensures that:
>A GP of the resident's choice or acceptable to the resident is made available to the

resident
> Where medical treatment is recommended and agreed by the resident, such treatment is facilitated
> The resident's right to refuse medical treatment is respected. Such refusal is documented and the matter brought to the attention of the resident's medical practitioner
> Residents are supported to access appropriate health information both within the residential service and available within the wider community
> Residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes
> Residents are supported to access allied health professionals as required.
>The staff team are committed to providing care and support in a kind and compassionate manner that respects and protects the rights. privacy, dignity and choice of each resident.

In response to the area of non-compliance found under regulation 6:
The Provider has ensured an emergency plan is in place within this designated centre for the GP to visit the resident in their home during times when an emergency medical assessment is required.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider has the following measures in place to ensure that:
Where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy, evidence based practice and with the informed consent of each resident, or his or her representative:
> A restrictive practice committee who approved and review all restrictive practices.
> A Multidisciplinary team which includes Psychology, Speech and Language, Behaviour Therapy, Psychiatry and Social Work.
> Registered Nurses trained in Intellectual Disability.
> Person Centred Care planning in place for each resident which is subject to a multidisciplinary review at least annually or should a change in need or circumstances arise.
> A schedule of mandatory staff training which includes Positive Behaviour Support and Safeguarding Awareness training in line with national policy.
> Regulatory 3 day and quarterly notifications to HIQA.
> A suite of policies and guidelines for staff which include;
*The use of Restrictive Procedures for the Management of Behaviours of Concern.
* Positive Behavioural Support and Behaviour Management.
*Risk Management and Emergency Planning
*Safeguarding Vulnerable Persons at Risk of Abuse.
*Open Disclosure policy
The person in charge ensures that;
Where a resident's behaviour necessitates intervention under this regulation every effort

is made to identify and alleviate the cause of the residents behaviour of concern, this includes;
> An individual assessment of need with a corresponding person centred plan which are subject to review.
> Referral to other departments as appropriate such as Psychology, Behaviour Therapy, Speech and Language and the Mental Health team to ensure all alternative measures are considered before a restrictive procedure is used; and the least restrictive procedure, for the shortest duration necessary, is used.
>Residents are provided with information on advocacy services, the Confidential Recipient, the Safeguarding Team, Complaints Officer and HIQA and are supported to access these services if they so choose.
>Staff have up to date knowledge and skills, appropriate to their role, to respond to behaviours of concern and to support residents to manage their behaviour.
>Staff receive training including refresher training in the management of behaviour of concern including de-escalation and intervention techniques.
> Staff training records are monitored and training is maintained within the required time frames.
> Routine audits to ensure compliance with this regulation which includes the audit of ;
• restrictive practices,
• accidents and incidents,
• safeguarding,
• complaints
• resident's personal plans.

In response to the area of non-compliance found under regulation 7:
The Provider has ensured that a review has taken place by the Behaviour Psychologist regarding all restrictive practices, and clear guidelines and protocols put in place regarding the use and recordings of these practices, in particular the use of physical restraint.

These practices are currently not being used as the resident is residing within Mental Health Services currently.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	30/04/2019
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	22/03/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the	Not Compliant	Orange	31/12/2019

	designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2019
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	31/12/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2019
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in	Not Compliant	Orange	31/12/2019

	accordance with paragraph (1).			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	30/04/2019
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	05/04/2019
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	22/03/2019
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each	Not Compliant	Orange	30/04/2019

	resident, or his or her representative, and are reviewed as part of the personal planning process.			
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	Red	30/04/2019