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:	Hazelwood
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Announced
Date of inspection:	13 November 2018
Centre ID:	OSV-0002336
Fieldwork ID:	MON-0021652

About the designated centre

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

Hazelwood is a residential service for six people, male and female, over 18 years of age with an intellectual disability. The centre is located in Dublin and is a five bedroom house with wheelchair accessible bedrooms and a bathroom. Each resident has their own room and there is a shared kitchen and dining room, two living rooms, a utility room and a large back garden. The house is led by a clinical nurse manager and is staffed by social care workers who are supported by a multidisciplinary team. The house has its own transport and is located in close proximity to public transport and a wide variety of social, recreational, educational and training facilities.

The following information outlines some additional data on this centre.

Current registration end date:	08/05/2019
Number of residents on the date of inspection:	5

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
13 November 2018	09:15hrs to 18:30hrs	Amy McGrath	Lead
13 November 2018	09:15hrs to 18:30hrs	Michelle McDonnell	Support

Views of people who use the service

The inspectors met three of the five residents who live in Hazelwood; some residents spoke with inspectors, and others engaged with inspectors with staff support. Residents' views were also elicited from resident questionnaires. The inspectors met with two family members of residents, who shared their views on the service received by residents.

Residents were observed in their home at various times of the day throughout the course of the inspection. It was observed that staff interactions with residents were respectful and considerate. Residents appeared comfortable in their home and one resident proudly showed inspectors around their house.

Family members spoken with were complimentary of staff, and expressed that residents identified the centre as their home.

Throughout consultation with residents and family, it was noted that there were concerns regarding the compatibility of residents in Hazelwood. Inspectors were informed that some support needs of residents could not be consistently met given the current mix of residents; this is discussed in further detail later in the report.

Capacity and capability

Overall, inspectors found that the governance and management arrangements were not effectively monitoring the quality or safety of the service. The inspection identified significant levels of non-compliance, some of which had been identified in the previous inspection in 2015, which had not been adequately addressed. Furthermore, assurances provided to the Office of the Chief Inspector in March 2018, relating to concerns raised on review of the providers' annual review of quality and safety, were also found to not have been implemented.

The inspectors found that although staff were knowledgeable of residents' needs, there were insufficient staff available to consistently meet these needs. The provider had not ensured that the centre was resourced to meet the needs of residents as assessed, or as outlined in their statement of purpose. Significant levels of non-compliance were found in the area of staffing, notification of incidents, admissions and contract of care, and complaints.

The provider had prepared a statement of purpose, which was reviewed at regular

intervals. Although it contained the information set out in Schedule 1 of the regulations, some information was inaccurate, or conflicting. For example, the organisational structure included staff members who no longer worked in the organisation. These inaccuracies were addressed by the person in charge on the day of the inspection.

There were policies and procedures in place for the matters set out in Schedule 5 of the regulations, each of which had been reviewed within a three year period. The inspectors found that the organisational policy on protection of adults from abuse and neglect contained information and guidance that was contradictory to the national safeguarding policy. Furthermore, the procedures contained within the policy were found to be inconsistent, and did not effectively guide staff practice.

Residents were supported by a team of social care workers, who were supervised by a person in charge. The staff employed in the centre were found to be appropriately qualified and experienced, and demonstrated good knowledge of residents' support needs. However, there were insufficient staff employed to meet the assessed needs of residents, which resulted in an over-reliance of agency or relief staff.

While there were efforts made by the person in charge to respond to the changing needs of residents, continuity of care was impacted by the volume of vacancies, and number of relief or agency staff used. For example, in one month, 17 different relief or agency staff worked shifts in the house, and for the month of November, there were over 500 hours not covered by regular staff.

The provider had implemented a schedule of training for staff, and a review of staff files found that staff had received mandatory training such as training in safeguarding adults, and fire safety. Records relating to staff training did not contain information on the dates that staff received training in managing behaviour that is challenging, and as such, inspectors could not determine if staff training and knowledge was up to date in this area. Whilst staff spoken with demonstrated an understanding of safeguarding issues there was some discrepancies in how incidents were being interpreted through the reporting mechanisms within the centre.

While there was evidence that the person in charge provided regular professional supervision to staff, there were no records of formal supervision between the person in charge and service manager. The person in charge and service manager both attended management meetings at intervals throughout the year, however inspectors found that the system of supervising the person in charge was not effective in ensuring that the senior management team had oversight of the quality and safety of the service.

The provider had carried out an annual review of the quality and safety of the service for 2017. This review prompted the Office of the Chief Inspector (OCI) to issue a provider assurance report to the provider (in March 2018), in relation to concerns regarding compatibility of residents; identification of safeguarding concerns; and notification of adverse incidents (as defined in the regulations). Inspectors found that the actions set out by the provider in the assurance report

had not been fully implemented for example, a review of incidents prior to April 2018 had been carried out, however safeguarding concerns were not escalated according to national policy, and were not notified to the OCI.

A review of incidents that occurred from July to September 2018 (carried out by the provider) identified 24 retrospective safeguarding concerns that had not been notified as required, or escalated to the national safeguarding and protection team, indicating that learning from the assurance report had not been embedded into practice. The provider had self identified this prior to the inspection.

The inspectors found that the person in charge had not notified the OCI of adverse incidents as required by the regulations. Inspectors found that there was conflicting information provided to the person in charge in relation to their responsibility to notify the OCI of incidents, and that the systems in place often prevented the person in charge from carrying out their statutory obligations.

A number of residents had been admitted to the centre since the previous inspection. On review of the admissions process for these residents, inspectors found that they were not carried out in line with the regulations, or the organisations own admissions policy. The provider had not carried out an assessment of need prior to the admission of new residents, and admissions practices did not adequately take into account the need to protect residents from abuse.

A review of the complaints procedure in the centre found that there were significant improvements required. While there was a complaint policy in place, complaints received were not managed in accordance with the providers own policy and procedure. It was found that complaints were not investigated promptly, complainants did not receive information with regards to their complaint, and there were no records of the satisfaction of the person making the complaints. Furthermore it was found that the complaints process was not being used appropriately, and that staff were not clear on the purpose of the complaints procedure. For example, residents were supported to make complaints about other residents, and not in relation to the service they were receiving.

Regulation 15: Staffing

Although the staff were suitably qualified and experienced, the number of staff was insufficient to meet the assessed needs of residents. There was an over-reliance on relief or agency staff, that impacted significantly on the continuity of care for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff were appropriately supervised. There was a training schedule in place, and for the most part, inspectors found that staff had received mandatory training, however records were not available for all training and as such the inspector could not determine if all training had been delivered within the providers' timescale.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems had not ensured that the service provided was safe, appropriate to residents' assessed needs, or was effectively monitored. The provider had not ensured that the centre was sufficiently resourced to deliver effective, safe, and quality care to residents.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Not all admissions to the centre had been carried out in line with the organisations' policy. Admissions practices failed to take into account the need to safeguard residents from potential abuse.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose, that contained most of the information set out in Schedule 1 of the regulations, however some information was inaccurate, and did not reflect the facilities within the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not notified the Office of The Chief Inspector of adverse incidents as set out in the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had prepared a complaints policy and associated procedures, and these were available in an accessible format. Complaints received were not managed in line with the organisations' policy; complaints were not investigated promptly, and measures required in response to complaints were not put in place.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The were written policies and procedures in place for all matters set out in the regulations, however the organisations' safeguarding policy was not reflective of national policy, and did not effectively guide staff practice in this area.

Judgment: Not compliant

Quality and safety

The governance and management arrangements had failed to ensure that residents consistently received a service that was safe and of good quality. While there were good care and support practices observed throughout the course of the inspection, it was found that the reporting mechanisms did not facilitate staff to raise concerns related to the quality and safety of care. Care and support was being delivered with insufficient resources and staffing; issues which had not been addressed by senior management. There were significant improvements required in relation to protection, premises, risk management and complaints management. Inspectors found that residents health care needs were well supported.

Each resident had a comprehensive assessment of need carried out, although not all had been conducted prior to admission. The assessments identified a wide range of

support needs, and there were corresponding support plans in place for any need identified. However, the arrangements in place were not sufficient to meet residents' needs on a consistent basis, and issues relating to compatibility of residents impacted on the ability of staff to support residents in accordance with their plans.

The person in charge had developed personal plans that were reviewed by a multi-disciplinary team, and ensured the maximum participation of residents and their representatives. While it was clear throughout the inspection that staff were knowledgeable of residents' support needs, limited resources restricted their capacity to meet all needs in a safe and effective manner.

Residents' health care needs had been identified through the needs assessment process, and the person in charge had ensured that residents had access to a general practitioner of their choice, as well as a range of allied health professions. Inspectors found that residents' health care needs were well supported, and that any specialist recommendations were followed up on and facilitated.

As mentioned previously in the report, the admissions process for some residents had failed to consider the safeguarding needs of residents, and some residents had not been subject to a needs assessment prior to admission. Consequently, compatibility issues had not been identified prior to the admission of a number of residents, and this greatly impacted on the quality of life for all residents. In some cases, residents' positive behaviour support needs could not be met, for example, one resident required a low-arousal environment to support their needs in relation to positive behavior, which could not be facilitated due to support needs of other residents. Inspectors were informed that some residents communicated by vocalising very loudly, and could keep other residents awake throughout the night. Inspectors witnessed this behaviour on the day of inspection, and found that there were prolonged periods of screaming and shouting throughout the day.

While there were arrangements in place to safeguard residents, inspectors found that these were not effective. Residents were regularly exposed to shouting, screaming, and being blocked from accessing their environment. A review of incidents in the centre, undertaken by the provider prior to inspection, found that there were numerous potential safeguarding incidents that occurred and had not been recorded appropriately or screened in line with national policy. Inspectors were not satisfied that the arrangements in the centre were protecting residents from the risk of abuse.

Furthermore, it was recognised by the provider that some behaviours of residents that impacted on the safety of others, were symptomatic of the environment they lived in, yet this had not been addressed in positive behaviour support plans or risk assessments. While there were detailed plans in place in relation to supporting people with needs in this area, inspectors found there was not sufficient effort made to identify and alleviate the cause of residents' challenging behaviour. Records of staff training did not contain details of training in positive behaviour support, and there was insufficient evidence to demonstrate that staff had adequate knowledge and skills appropriate to their role.

Inspectors found that although residents' general welfare was negatively impacted by their living environment, there were arrangements in place to support residents' personal development, such as access opportunities for occupation and recreation. Residents each attended a day service, and were supported to develop and maintain personal relationships and links with the wider community. Residents regularly had family and friends visit them in their home, and enjoyed trips away, and meals in local pubs and restaurants.

A review of incidents found that arrangements and resources did not ensure that residents could exercise choice in control in their daily lives. For example, on one occasion residents were prevented from leaving the premises due to the behavioural needs of another resident.

There were risk management systems in place to identify and address risk. A review of risk assessments found that although the person in charge had a good awareness of risks in the centre, and had identified risks to residents safety and quality of care, the control measures identified were not reflected in practice, often due to staffing deficits. As a result control measures were ineffective in managing risk, for example, multiple risk assessments identified sufficient and familiar staff as being essential in managing the identified risk.

The provider had reviewed the fire safety arrangements for the centre, and this review found some issues in relation to fire containment measures. While it is acknowledged that an action plan had been developed, which identified that works to address this risk would be completed by December 2018, at the time of inspection there were insufficient fire containment measures in place. The provider had ensured that there were adequate arrangements in place for staff to receive training in fire safety. There were personal emergency evacuation plans in place for residents, and these reflected learning from fire drills that residents and staff participated in at regular intervals.

There were significant improvements required in the maintenance and decoration of the premises. While the layout was suitable in meeting residents' needs, there were outstanding works from the previous inspection in 2015, such as damaged walls and skirting. Inspectors observed broken furniture in some resident's rooms, and there was insufficient storage available in the centre, with items stored on the floor in communal areas. Some Schedule 6 matters had not been appropriately provided for, such as cooking equipment and tableware.

A review of medication management found that there were appropriate practices in place in relation to the ordering and receipt of medicines; however not all medicines were appropriately stored. Inspectors found that the guidance in relation to administration of PRN medicines was insufficient to guide staff practice, and improvements were required to ensure that guidance contained enough detail to support the appropriate administration of PRN medication.

Regulation 13: General welfare and development

Overall, residents were supported to enjoy meaningful and active lives. They were provided with opportunities for occupation and recreation, and were supported to access opportunities in line with their preferences and abilities. However, it was found that on-going issues with compatibility had a negative impact on the lived experience of residents on a daily basis, which impeded on their abilities to engage in some activities.

Judgment: Not compliant

Regulation 17: Premises

There was significant improvement required to the maintenance and decoration of the premises, with some issues, such as damaged to door frames and skirting, outstanding since the previous inspection in 2015. Not all matters as set out in Schedule 6 of the regulations had been provided for, for example, adequate tableware.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment and management of risk, and while the person in charge demonstrated knowledge of risk in the centre, the control measures within risk assessments were not reflective of practice. For example, in some cases the control measure to mitigate risk was ensuring there were sufficient and familiar staff present, which could not be maintained.

Judgment: Not compliant

Regulation 28: Fire precautions

There were fire safety management systems in place, including a review of fire safety by a competent person. There were arrangements in place for the safe evacuation of residents. Improvements were required in the containment measures within the premises, although this had been identified by the provider and works were scheduled to be complete by the end of 2018.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were improvements required to ensure there was appropriate guidance in relation to the administration of PRN (medicines only taken as the need arises). Not all medication was appropriately stored.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The needs of residents had been comprehensively assessed, and there were support plans in place for identified needs. However, the arrangements in place were insufficient in meeting the assessed needs of each resident.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to maintain good health, and had access to a range of allied health professionals. Residents' health care needs were identified and supported in line with specialist recommendations.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behaviour support plans in place for any resident who required support in this area. There were no records available in relation to staff training in managing challenging behaviour, and it could not be determined if staff were appropriately trained in this area. Where restrictive practices were utilised, these were recorded and reviewed to ensure they were used in line with best practice, however improvements were necessary to ensure that every effort was made to alleviate the cause of the resident's challenging behaviour.

Judgment: Not compliant

Regulation 8: Protection

While there were arrangements in place to keep residents safe, inspectors found that safeguarding concerns were not being escalated as per national policy. Residents were regularly exposed to behaviours such as shouting, pushing, and being blocked from accessing their environment, and while residents were supported by staff in the centre during these incidents, the systems in place did not ensure that these incidents were screened appropriately in order to protect residents.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were not consistently supported to participate in and consent to decisions about their care and support, or to exercise choice and control in their daily lives.

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
Views of people who use the service	
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	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Hazelwood OSV-0002336

Inspection ID: MON-0021652

Date of inspection: 13/11/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In response to the area of non-compliance found under Regulation 15(1) and Regulation 15(3) • A full roster review has been completed to identify staff vacancies. • All necessary HR and employment control paperwork has been completed for 6 staff vacancies. • 6 staff will be recruited and in post having received organisational orientation and safeguarding training • The planned and actual rosters for Feb, March, April and May 19 will be reviewed by the PIC, Service Manager and Admin Manager to ensure that the numbers and skill mix of staff are appropriate to meet the needs of the service users.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In response to the area of non-compliance found under Regulation 16(1)(a) The Person in charge will liaise with the organisations training department and will review and update all required mandatory training for the centre and schedule additional	

training for the staff team as identified under regulation 9.

In response to the area of non-compliance found under Regulation 16(1)(b)
The person in charge will complete a schedule of supervision meetings with the staff team in the centre.

The Service Manager has scheduled dates with the Person in charge for management meetings on a monthly basis.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In response to the area of non-compliance found under Regulation 23(1)(a)

Staff resources for this designated centre will be discussed and prioritised with the Executive Management Team and a report for the Board of Directors will be prepared outlining the resources required and the actions agreed to support this designated centre.

In response to the area of non-compliance found under Regulation 23(1)(b)

A clear management structure is in place with lines of accountability, authority and specific roles and responsibilities.

In response to the area of non-compliance found under Regulation 23(1)(c)

Monthly data sheets have been introduced in the centre and will include information and analysis of accidents /incidents/ behaviours that challenge/ peer to peer interactions/ complaints. These will be discussed and necessary actions agreed by the PIC and Service Manager at their monthly meetings and at the fortnightly governance meetings.

In response to the area of non-compliance found Regulation 23(2)(a)
A review of actions from the 6 monthly reports and most recent annual review of the service will be undertaken to identify and prioritise actions for implementation.

A schedule of internal audits will be developed for 2019. These will include a Health and Safety Audit, Risk assessment and risk register audit, Medication audit, Assessment of Need and support plan audit, Fire safety audit, audit of service users monies and a staff training audit. A QEP with actions to be completed will be updated following the audits. This will be reviewed as part of the PIC/ Service Manager monthly meetings

An additional 6 monthly audit focusing on Governance and Management will be carried

out in the centre to ensure the systems introduced are improving the governance arrangements.

In response to the area of non-compliance found Regulation 23(3)(a) and Regulation 23(3)(b)

Fortnightly governance and management meetings with PIC, Service Manager, Director of Service and Director of Quality Improvement and Safety Development will be established. Minutes will be kept identifying what needs to be done, by whom and by when.

Supervision and support meetings for the Staff Team, PIC and Service Manager will be scheduled and matters discussed will be documented. Staff meetings and cluster meetings will continue and will form part of support and supervision arrangement s for the staff in the designated centre.

At the supervision meetings with Staff, PIC and Service Manager a standing item on the agenda will be to discuss any concerns staff members have about the designated centre or the care provided to service users. These will be included in the notes of the meeting and will be discussed at the fortnightly governance and management meetings.

The PIC will have additional management time on the roster to support improvement in Governance and Management

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
In response to the area of non-compliance found under Regulation 24(1)(a), 24(1) (b) and 24(4) (a)

All future admissions will be compliant with Regulation 24 prior to admission

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
In response to the area of non-compliance found under Regulation 03(1)

The person in charge has updated the Statement of purpose in line with schedule 1.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In response to the area of non-compliance found under Regulation 31(1)(f)
All adverse incidents are notified to the Authority as NF 06. PIC and Service Manager will report all incidents of safeguarding to the Principle Social Worker for preliminary screening.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
In response to the area of non-compliance found under Regulation 34(2)(c), Regulation 34(2)(e) and Regulation 34(2)(f)

Accessible information in relation to complaints is available in the centre and complaints will be discussed with residents at residents meetings or individualised meetings.

The Person in charge and the Service manager will review all complaints in the centre and all measures required to respond to each complaint will be actioned.

The person in charge will keep a record of all complaints and outcomes of the complaint, clearly identifying if the resident was satisfied with the outcome, in line with organisational policy.

The person in charge will complete the monthly data report which includes an area for complaints and status of complaints.

Complaints will be a set item for discussion and review with the PIC and Service Manager during their monthly meetings

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
In response to the area of non-compliance found under Regulation 04(3)

The following steps have been taken by the provider in relation to reviewing and updating the organisations safeguarding policy and guiding staffs practices in this area.

Safeguarding committee has been established and policy review will be included in the Terms of Reference

Research and Consultation with key stakeholders will be completed

Draft 1 of reviewed policy reviewed by Social work team/ Safeguarding Panel/ Executive Management Team.

Draft 2 of updated Safeguarding Policy prepared based on feedback on draft 1

Consultation on draft 2 will be completed
Policy Finalised and Implementation plan developed by the 30/06/2019

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
In response to the area of non-compliance found under Regulation 13(1)

Monthly data sheets will be introduced in the centre and will identify when service users have opportunities for community participation and engagement. It will also identify when those opportunities are limited due to staffing/ behaviour of others.

A review of assessment of needs and support plans will be undertaken to identify additional opportunities for community participation

The monthly data sheets will be reviewed for General Welfare and Development Opportunities/ missed opportunities during Dec/ Jan/ Feb.

Missed community participation opportunities due to staffing/ behaviour of others these will be considered as rights restrictions as outlined in Regulation 9. A rights restoration

plan to support individuals to achieve the level of community engagement they are seeking will be developed

A review of compatibility of service users in the centre will be undertaken

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In response to the area of non-compliance found under Regulation 17(1)(b), 17 (1) (c) and 17 (4)

SMH TSD has visited the centre and all identified works have been identified and schedule of works will be in place.

The person in charge has developed a cleaning schedule for the centre to ensure the centre

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In response to the area of non-compliance found under Regulation 26(2)

A review of the risk register and risk assessments in the centre will be undertaken to ensure they are up to date and reflect the control measures that are in place.

Risk assessments and the risk register will be updated based on the review above

Refresher Training for PIC/ PPIM/ Other staff in the centre on risk assessments and risk management will be scheduled

The Registered Provider will review the Risk Management Policy to ensure it guides practice in assessing risk, recording risks and escalating risks where appropriate.

A review of the risk register following the implementation of additional control measures outlined in the strategies in the regulations above will be conducted to ensure the risks in the centre have reduced.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In response to the area of non-compliance found under Regulation 28(3)(a)

All fire containment measures will be addressed by end of first quarter 2019 in line with the organisational fire risk register.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
In response to the area of non-compliance found under Regulation 29(4)(b)

All PRN guidelines will be updated and all medication will be stored appropriately

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:
In response to the area of non-compliance found under Regulation 05(1)(a) and Regulation 05(2)

The person in charge and relevant key-workers will review and update all residents assessment of need and support plans

The Director of Service has commissioned an Enhanced Multi Element process review in the centre.

All About Me's for all residents will be updated/ developed to reflect what is important to each individual

A schedule of annual Outcome Review meetings will be developed with relevant Clinicians in attendance

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The unit psychologist will update PBS plans as required.
Formal training for staff members in PBS will begin in January 19.
Restrictive practices will be reviewed monthly in future.
Enhanced multi-element assessments will be completed to assist in understanding the cause of challenging behaviour and identifying measures to alleviate this.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A full desk-top review of peer to peer incidents has been carried out by the designated officer to identify peer to peer safeguarding issues and retrospective NF 06 submitted to the Authority

Safeguarding Plans for each service user have been developed based on this review and will be implemented in the designated centre

Information session on reporting and management of Safeguarding concerns to social work department and The Authority have been held with staff team and PIC.

PIC and Service Manager will report all incidents of safeguarding to the Principle Social Worker for screening as safeguarding concerns. These concerns are notified to the Authority as NF 06

Fortnightly governance and management meetings with PIC, Service Manager, Director of Service and Director of Quality Improvement and Safety Development will be established. A standing item on the agenda is a review of peer to peer behaviours for previous period and the NF 06 submitted.

PIC will seek feedback from the staff team (at staff meetings) on implementation of safeguarding plans and will review and update as necessary

A DSAMT has been completed and submitted to the HSE for additional resources.

A full review of safeguarding support and their implementation will be held. This will include a review of safeguarding concerns for Nov/ Dec/ Jan, the implementation of the safeguarding support plans for individuals and the notifications submitted to HIQA will be held and any outstanding safeguarding concerns will be identified.

The multi-element support plan will be completed and strategies for the management of challenging behaviour for one service user will be identified. The multi-element support plan will include a functional assessment of the behaviours that challenge and specific recommendations' for the residents residential placements.

The Director of Service will convene a multi-disciplinary meeting to review the multi-element support plan and agree implementation strategies.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Rights training for the PIC and staff team will be scheduled

Each Keyworker will conduct a Rights Audit based on the training to identify where rights are restricted

A rights restoration plan for each person will be developed by the keyworkers and reviewed by the Person in Charge

The rights audit will be repeated in Sept 2019 to provide assurance that the rights restoration plans have been implemented and effective.

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	30/06/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/05/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on	Not Compliant	Orange	30/05/2019

	a less than full-time basis.			
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	30/04/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/01/2019
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption	Not Compliant	Orange	31/03/2019

	and inconvenience to residents.			
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	30/03/2019
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	21/12/2018
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	30/03/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety	Substantially Compliant	Yellow	30/03/2019

	and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/01/2019
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	31/01/2019
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	21/12/2018
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Orange	21/12/2018

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	21/12/2018
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	30/03/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/03/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/01/2019
Regulation 03(1)	The registered provider shall prepare	Substantially Compliant	Yellow	13/11/2018

	in writing a statement of purpose containing the information set out in Schedule 1.			
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	13/11/2018
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Not Compliant	Orange	31/01/2019
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/01/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	31/01/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief	Not Compliant	Orange	30/06/2019

	inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	21/12/2018
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	31/03/2019
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/03/2019
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	Not Compliant	Orange	31/01/2019

	techniques.			
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	30/03/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	13/11/2018
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	Red	13/11/2018