Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Florence House
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	10 December 2019
Centre ID:	OSV-0002632
Fieldwork ID:	MON-0023343

About the designated centre

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

This centre provides a residential service for up to ten male and female residents. The profile of the residents that this centre caters for is set out as those with a severe to a profound level of intellectual disability. At the time of this inspection, there were eight residents living at the centre and the centre had a capacity of ten residents. The centre is located in a housing estate on the outskirts of a large town. This centre is open 24 hours a day and seven days a week. It is staffed with a person in charge, nurses and multi-task workers. The residents were of a similar age profile. The building consists of two floors, with the ground floor being open to residents and the upstairs floor used for other purposes. An outside area was available to residents and this had some recreational equipment used mostly in the summer months. Residents have access to facilities in the town and a nearby day service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Tuesday 10 December 2019	09:05hrs to 17:55hrs	Carol Maricle	Lead

Views of people who use the service

The inspector met with seven of the eight residents. The residents did not communicate verbally with the inspector therefore the inspector spent time with the residents by sitting alongside them and observing them as they went along their day interacting with each other and with staff.

The residents were observed dining, relaxing, getting ready to leave the centre and engaging with in-house programmes.

The residents appeared mostly comfortable and content. Some residents were observed receiving in-house aromatherapy. Others were observed engaging in activities with staff. Some were observed sitting by themselves and engaging with their favourite items. A number of residents went out to their day service in the morning and others were observed leaving the house in the afternoon.

The residents were observed communicating with staff in their own unique style using body language, utterances and facial expressions. The residents were spoken with by staff in a well-intentioned manner however this was observed by the inspector to not always be in fitting with their age.

The majority of residents required two to one support when mobilising and when staff were busy residents were observed waiting for support. Although this did not appear to result in any obvious signs of distress, the inspector observed some episodes of residents presenting as restless and seeking out interactions with staff and the inspector.

Capacity and capability

This was an unannounced inspection of the centre. Overall, despite a management and governance structure in place there was a high number of non-compliances identified at this centre.

A person in charge (clinical nurse manager CNM2) had been appointed at this centre in the weeks prior to this inspection. She, along with a clinical nurse manager (CNM1) formed a newly appointed management team. They in turn reported to a team of managers involved in the day-to-day management of the centre. During interview with staff they confirmed to the inspector that they always had a member of the management team available to consult with and report to. The person in charge set out to the inspector the plans she had to drive improvements

in standards at the centre and gave examples of changes already introduced since her appointment.

The provider had put in place arrangements to ensure that there was governance and management at the centre and there was a suite of management auditing tools used. The centre had received a six monthly unannounced inspection and an annual review of the centre had been completed. The centre also received a series of unannounced monthly audits. However, despite these audits taking place, a clear action plan arising from same was not in place. It was difficult to identify the findings, the actions required to address findings and the persons responsible to address each finding. The annual review of the centre could not be located on the day of the inspection which was of concern to the inspector but was forwarded to HIQA following the inspection. This annual review again did not have a summary of all findings compiled, named persons responsible to address the findings and clear timelines outlined. Overall, this meant that although there were systems in place to measure the care being provided to residents there was poor oversight of each audit and it was therefore difficult to assess if the audits led to an improvement in the quality of life for each resident.

The statement of purpose forwarded to HIQA following this inspection contained a number of inaccuracies. In particular the capacity of the centre was not accurate. The capacity was ten residents and there were eight residents at the time of the inspection. The inspector was told by the person in charge that the centre was not at present open to admissions. The statement however set out that the capacity of the centre was eight. Not all rooms at the centre matched the description as set out in the statement. The description of the first floor along with its purpose was not suitably set out in the statement.

There was some evidence to show that the provider used, collected, evaluated and responded to information that informed, improved and sustained a quality service. The person in charge attended fortnightly management meetings during which all incidents that took place were discussed and timely actions taken.There were systems in place for complaint making. The person in charge had commenced a review of personal planning arrangements. The relevant statutory notifications had been made to HIQA and there were systems to support the notification process.

Overall, there was insufficient documentation to show that the resources at the centre matched the requirements of the residents as the allocation of resources was not set out clearly and linked to the needs of each resident. This meant that aspects of the running of the centre was based on resources available to the person in charge on a daily basis rather than being driven by each resident.

The person in charge told the inspector that staffing levels, staff sickness and staff turnover were issues at the centre however she did have available to her agency staff to fill vacancies and that this meant that the roster was filled each day. She told the inspector that behaviours of concern directed at staff by residents could be attributed in some cases to lack of familiarity by residents with the staff who were supporting them. In relation to the vetting of staff, the person in charge confirmed that she did not have oversight of the qualifications and vetting information of

agency staff. There was no formal risk assessment completed as part of the centre risk register of the impact that staff turnover was having on the residents in general.

On the day of the inspection there were two vehicles that could be used by residents, however, one of these vehicles had not been available to the residents for a number of months prior to this inspection. The inspector was told by a staff member that not all staff drove these two vehicles meaning that opportunities for residents to use these vehicles was dependent on who was on duty that day and whether the staff on duty could or could not drive the vehicles.

The night-time staffing ratio was two staff to eight residents from 8.30pm. The inspector was told by the person in charge that this meant that the residents did not usually leave the centre after this time. There was no risk analysis of these arrangements and the impact they had on the wellbeing of the residents. There was no analysis of the wishes, needs or abilities of the residents to engage in activities at this time of the evening. The staffing ratio at the weekend was also different to that of a week day with less staff on duty again impacting the ability of residents to leave the centre.

The oversight of record maintenance was poor. Records relevant to residents were not kept in good order, easily retrievable and archived appropriately. Information no longer pertinent to residents was kept in their working files which meant there was confusion when looking at personal planning documents. The lack of a coherent paperwork system in a centre that had a high turnover of staff meant that the records were difficult to navigate and thus increased the risk of poor care as the necessary information was not prominently displayed in each file. The person in charge had to ask staff to provide her with information on where each resident was supposed to be on the day of the inspection as this information was not set out clearly in the files of residents.

Regulation 15: Staffing

The registered provider could not ensure that staffing levels at the centre were in line with the needs of the residents as a formal assessment of the staffing requirements of each resident had not been carried out.

The person in charge did not ensure that they had obtained in respect of agency staff the information and documents set out in Schedule 2 of the Regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge oversaw the completion of staff training. There was register of training that was a live register. The person in charge identified to the inspector that where there were training gaps then training dates had been confirmed.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider did not ensure that records were maintained at the centre in an appropriate manner.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had put in place systems for the governance and review of the centre. An annual review of the centre could not be located on the day of the inspection but was submitted to HIQA directly thereafter. A six monthly unannounced inspection had been conducted. A clear action plan arising from the six monthly unannounced inspection and annual review was not in place.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had ensured that written terms and conditions were in place however there was incorrect information on the terms and conditions regarding the pathways of how to make a complaint.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider did not ensure that the statement of purpose met the requirements of Schedule 1 of the Regulations. The capacity of the centre was not correctly set out. The floor plans and description of each room did not match what was seen on the day of the inspection. The names of all persons participating in the management of the centre were not all set out. The current admission policy described to the inspector was not set out.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had ensured that incidents that required notification to HIQA had been submitted. The provider had put in place systems to ensure that incidents were brought to the attention of the management team in a timely fashion in order to ensure that the relevant statutory authorities were notified.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had ensured that there were systems in place to manage the receipt of complaints. There had been four complaints received over the previous 12 months and these had been resolved.

Judgment: Compliant

Quality and safety

Overall, while there were systems in place to ensure residents were supported and cared for, the same systems did not equate to a person-centred and rights based service.

Residents were supported by a team of multi-task workers and nurses and all staff had access to continued professional development. On the day of the inspection, the residents were observed and documents showed that residents were in receipt of the required supports in their healthcare. Residents had access to a suite of healthcare services provided by both the provider and primary healthcare services. Each resident had their healthcare needs assessed by a nursing staff member. Residents had healthcare support plans. There were routines in place to ensure that residents were supported in their personal care. Dietary requirements and preferences of each resident were known by staff and written information confirmed this support. Staff were observed being highly vigilant to the mobility requirements of each resident. Residents had communication plans that assisted staff to communicate with them.

Residents were protected at this centre. There were systems in place to manage complaints. Where required, residents had an individualised behavioural support plan in place. Staff were trained in adult safeguarding. Residents were supported to visit their families. A visitor room was in the final stage of refurbishment. The residents had their own bedrooms, refurbished since the previous inspection.

Despite these positive findings, there remained a number of non-compliances.

The person in charge maintained a risk register and each resident had a set of individualised risk assessment however notwithstanding this system in place, there was a lack of risk assessment of significant matters at the centre. The person in charge discussed and showed the inspector the relevant risk analysis of a staff-ratio issue with reference to the impact that this had on the safety of a particular resident and confirmed that this had been escalated by her line manager to the

general manager. There was evidence that controls were put in place to mitigate against the risk. The inspector did not find that all hazards identified at the inspection had been identified for risk assessment and control, for example, the actual risks to each resident should they enter the kitchen without being accompanied by staff was not assessed. The risk posed by residents not attending their allocated day service hours was not assessed. The risks posed by residents accessing their dining room outside of meal-times was not assessed.

The lack of a weekly planner devised for each resident coupled with a lack of a documented assessment of their staffing ratio requirements meant that the inspector could not tell from documentation viewed if each resident was enjoying optimal support and a fulfilled life in line with their rights, wishes and goals. Some residents were observed leaving to attend their day service however the person in charge told the inspector that while the residents attended on the day of the inspection this was not always the case. The inspector reviewed a sample of record sheets showing daily activities that in themselves showed gaps in record keeping. These also did not set out whether the residents had in fact attended their scheduled day service for that day. It was difficult to determine the extent of whether the residents attended day service or not as each resident did not have a weekly planner that set out their expected activity schedule.

Each resident had an individualised care plans that consisted of a running file, a medical file and a personal file. There was evidence that the information in the file was regularly reviewed and added to by staff members. Each resident had a set of goals created annually. However, there was no formal review of the effectiveness of the personal planning arrangements. The overall condition of the personal file viewed was poor. It was difficult for the inspector to navigate through the documents. There were reports on file with no date or author. Documents were not version controlled. The inspector showed some documents to the person in charge who confirmed that some of the documents were no longer valid and required archiving. There was significantly poor records kept of the achievement by the residents of their goals. The risk to the resident of these findings meant that the effectiveness of their personal planning arrangements could not be determined easily due to the poor standard of paperwork maintained.

The centre had a number of environmental restrictive practices in place. Residents could not access their kitchen and dining room of their own free will which was described as necessary to keep residents safe, however this had not reviewed in the context of the rights and capabilities of each individual resident. In the dining room, there was an over-sized dresser and all access to this dresser was restricted due to the component parts being locked. During meal-times staff were observed opening and locking compartments of this dresser with their keys when getting required items which did not lend itself to a homely experience. There were no kitchen items, photographs or ornaments placed on this dresser which one would usually find in a home. One of the residents was observed trying to access compartments of the dresser and was encouraged by staff to leave the room to distract them from this behaviour.

The dignity of the residents was not at all times upheld. Although staff were

observed engaging warmly with residents they frequently spoke with the residents in a manner that did not equate to their age. A resident was observed wearing a 'bib' fashioned from kitchen towel paper and placed over their head, this was observed as not to be in keeping with their age and dignity. The dining atmosphere was not consistent with an enjoyable dining experience as tables were not set, there was significant noise from a healthcare appliance and limited decorative furniture. A resident was observed receiving a healthcare treatment while others ate their meals in the dining room which did not lend itself to a peaceful and relaxing environment for both the residents and their fellow peers. Another resident was observed playing with their preferred items in the dining room but the storage of these items was in a small refuse bin placed on a table which although did not interfere with their enjoyment of said items the rationale for using this type of storage rather than an appropriate container was not clear. The person in charge had not ensured that there were effective systems in place to ensure residents were supported to buy, prepare and cook their own meals.

Overall the premises was found to be clean on the day of the inspection. A main bathroom on the ground floor used daily by residents was without ventilation which according to staff became uncomfortable when in use for both the residents and staff. The inspector noted a malodour in this room. One of the communal rooms in the home had a portable folding table set up in an area of the room which did not contribute to a homely appearance and did not seem to fulfill any purpose.The bedroom doors of the residents were all kept open during the day and there was no clear rationale for same.

The actual use of the entire first floor was not set out in the statement of purpose nor the resident guide and could not be used by the residents. This was used by staff during their breaks, for the storage of unused furniture and for the storage of a considerable number of boxes containing paperwork from the centre and other services within the provider. At the feedback meeting, a person participating in the management of the centre could not give assurances that the storage of these files did not present as a fire hazard given the quantity of files stored. There was no plan in place to deal with unused furniture stored throughout the centre over the two floors. In the ground floor of the centre, a vacant bedroom was used for storage and was cluttered. A bed frame was found in a fuse room on the ground floor.

Regulation 10: Communication

The registered provider had ensured that each resident had their own communication plan. There was a speech and language therapist available for residents as part of the provider led suite of services.

Judgment: Compliant

Regulation 11: Visits

The registered provider had ensured that the residents were supported by staff to visit their families. There was also a newly decorated visitors room at the centre that was nearing completion.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider had not ensured that there was documented evidence to show that opportunities were provided to residents to attend and participate fully in education, training and employment. It was not clear from residents files their day service programme nor their attendance at same. Their attendance at same was reported by the person in charge to be inconsistent.

Judgment: Not compliant

Regulation 17: Premises

The registered provider had not ensured that the premises was maintained to a high level as there was a high level of clutter and unused furniture throughout. The upstairs area was used to store boxes of archived paperwork from this centre and other services operated by the provider. A bathroom was without ventilation and the impact that this had on the residents had not been assessed.

Judgment: Not compliant

Regulation 18: Food and nutrition

The person in charge had not ensured that there were effective systems in place to ensure residents were supported to buy, prepare and cook their own meals.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that all hazards at the centre were assessed, managed and risk rated.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not ensured that there was an analysis of the risk posed by a significant amount of paperwork stored in the upstairs floor of the centre. There was one gap identified in the frequency of monthly fire drill records.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had not ensured that the personal plan for each resident reflected the needs of the residents and outlined the supports to be provided. The effectiveness of the plan was not assessed.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had ensured that appropriate healthcare was provided to each resident. Residents were supported by staff to attend all relevant healthcare appointments.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that systems were in place to support residents in their regulation of their emotions. A behavioural therapist was available to support the residents in this regard. At the time of this inspection, only a small number of

residents required support in this area.

The registered provider had not ensured that restrictive practices in place across the centre followed national guidance and best practice.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had ensured that there were systems in place to ensure that residents were kept safe. Residents had intimate care plans developed. Staff were trained in adult safeguarding.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had not ensured that the privacy and dignity of the residents was upheld at all times.

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 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	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	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Florence House OSV-0002632

Inspection ID: MON-0023343

Date of inspection: 10/12/2019

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.

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: Nationally there isn't an assessment tool to determine individual resident to staff support needs however we have carried out a comprehensive review and risk assess on a continuous basis to identify the support needs of each resident. Due to a change in need an additional WTE has been appointed to the roster with effect from Monday 13th Feb. The HSE are working with the Nursing Agencies to ensure the provision of all appropriate Documentation to ensure regulatory compliance. A letter of verification in relation to training and qualifications is held on file on an interim 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: Training dates have been set for the staff outstanding in certain mandatory training: Fire Training: 1 staff outstanding is scheduled to attend training on 27th Feb, as they had just commenced employment at the time of inspection. Local induction in relation to fire was carried out on his first day.	

Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A full in-dept audit into resident's records is currently being completed. All documents that are out of date have been archived and a more structured system is currently being implemented which will promote a more easily retrievable care plan system. Copies of activity schedules for all residents have been placed in the appropriate records which will be easily available for staff to view and document on a daily basis. The care plan system will be audited regularly to ensure all care plans are of high quality. All archive documentation held on site will be reviewed culled and boxed before being transferred to a designated HSE archive unit.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Action plans section has now been added to the monthly unannounced inspections where the PIC will address any findings and give clear timelines for completion of same. The same will apply to six monthly and yearly inspections.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: Section of the contracts regarding complaints has been reviewed and amended referencing the HSE complaints management policy and new contracts are being issued for signing.	
Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The statement of purpose has been revised and the information pertaining to the capacity of the centre, floor plan and management structure has been amended.	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: Residents individualized activation programs have been reviewed in conjunction with the Day Centers revised program, ensuring that enough flexible is incorporated to support residents receive a meaningful variety of activities in the event of reduced resources being available due to supporting residents to attend Out patients apts.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Furniture has been removed from the spare room and the room has been redesignated as a therapy room. All archive documentation held on site will be reviewed culled and boxed before being transferred to a designated HSE archive unit. A risk assessment has been completed regarding the impact of lack of ventilation in the large bathroom and all control measures put in place.	
Regulation 18: Food and nutrition	Not Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: The residents are now supported to complete a weekly shopping list and do a weekly shop in the local supermarket which will promote choice with regard to what meals they would like to prepare. All breakfast choices are made freshly each morning depending on	

the resident's choice. Snacks and drinks are also available when requested. The new activity timetables being introduced will include baking and cooking sessions with the residents which will encourage more input from the residents into buying and preparing of food in the house.

Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Risk assessments were completed for residents in relation to: Accessing the kitchen in the absence of staff support Impact on residents of non-attendance at day services Full review of the current risk register in place is to include all new risks identified.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All archive documentation held on site will be reviewed culled and boxed before being transferred to a designated HSE archive unit. The PIC has addressed the gap in the monthly fire checks with all staff.	

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: Thorough review of all personal plans ongoing incorporating relevant action plans. Correspondence issued to all staff regarding referencing guidelines and requirements.	

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Restrictive practices in place in relation to the dining room storage and the Kitchen have been referred to the Restrictive Intervention Rights Committee for review and individual residents have had their risk assessments and associated supports plans reviewed in relation to access to the kitchen.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A Developing Cultures of Person Centeredness group has been reestablished within the service. The PIC is involved in facilitating this group which focuses on various issues such as person centered language. This group will share and feedback all the information discussed and plans devised to all staff members to ensure a culture of person centeredness within the service. New more appropriate clothes protectors have been purchased for meal times and the dining room is in the process of being made more homely. The residents will now be involved in various aspects at meal times such as setting the table.
Adherence to Protected meal times policy is enforced.

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(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	03/02/2020
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	13/02/2020
Regulation 15(5)	The person in charge shall ensure that he or she has obtained	Not Compliant	Orange	01/04/2020

	in respect of all staff the information and documents specified in Schedule 2.			
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	27/02/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	01/04/2020
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Not Compliant	Orange	03/02/2020
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	03/02/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the	Not Compliant	Orange	17/02/2020

	effective delivery of care and support in accordance with the statement of purpose.			
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	03/02/2020
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 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.	Not Compliant	Orange	03/02/2020
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the	Substantially Compliant	Yellow	28/02/2020

	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.			
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	03/02/2020
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	01/04/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is	Substantially Compliant	Yellow	03/02/2020

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	01/02/2020
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/02/2020
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Not Compliant	Orange	31/03/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental	Not Compliant	Orange	25/02/2020

	restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Substantially Compliant	Yellow	01/03/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	01/03/2020