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:	Graifin House
Name of provider:	RehabCare
Address of centre:	Dublin 18
Type of inspection:	Unannounced
Date of inspection:	03 September 2019
Centre ID:	OSV-0002636
Fieldwork ID:	MON-0024749

About the designated centre

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

This community based residential centre operated by Rehabcare provides a high support residential service for adults with Prader-Willi Syndrome (PWS). Each individual has complex needs in relation to their PWS, pertaining to food, behaviour that challenges, and mental and physical difficulties. The house is a two storey, six bed roomed building located on a main road in a suburban area in Co. Dublin. Residents can also access the building from a side entrance. A large garden area is available to the front and side of the premises. Each resident has their own single room with one located on the ground floor and four on the second floor. The house is close to a broad range of services and amenities, with a public transport system also locally available. There is capacity for five residents and they are supported over the 24 hour period by care support workers, two team leaders and the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
03 September 2019	10:30hrs to 19:30hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

The inspector of social services found that residents were enabled to make choices which supported and promoted residents to make decisions about their care. Residents were actively supported and encouraged to maintain connections with their families through a variety of communications and visits. The residents also told the inspector about some of the activities that they participated in such as arts and crafts, walks and trips out for coffee. They also indicated that they were very happy with many parts of life in the centre such as their bedrooms, activities and the staff who supported them. The residents also told the inspector about some of the activities that they participated in such as arts and crafts, walks and trips out for coffee.

There were three residents present on the day of the inspection. There was one vacancy, and one resident was enjoying a break with their family. The inspector was able to spend some time with these residents on their return from day programmes and before they went out on social activities. The inspector observed that residents were comfortable with the support provided by staff on the day of inspection. Residents were seen telling staff about their day.

Residents spoke with the inspector about the things they are interested in and what is important to them. One resident had a clear goal and was visibly proud of the progress made to date towards achieving this goal.

During the inspection, the inspector became aware about alleged peer to peer incidents that occurred in the centre and how this affected residents. This was discussed with the person in charge in line with similar complaints made in the previous six months.

Capacity and capability

The inspector found that while there were governance and management arrangements in place to monitor the quality and safety of the service, these required further review and development. Improvement was also required to ensure that there was effective oversight of key areas, including safeguarding, residents finances, the notification of adverse incidents, the follow-up and completion of actions from quality improvement plans and the centre's own monitoring systems.

The purpose of this unannounced inspection was to monitor the centre against compliance with the regulations and to assess the provider's own quality improvement plan as submitted to the Chief Inspector of Social Services in October 2018. The quality improvement plan had been requested by the Chief Inspector due

to the receipt of unsolicited information concerning governance and staffing arrangements.

There was evidence of clear reporting structures in the centre. The person in charge had been in this role since September 2015. They were line managed by the services manager and in turn supported in the management of the centre by two team leaders. The person in charge returned from statutory leave in May 2019, and a team leader had been appointed to the position of person in charge in their absence for six months.

The provider had carried out an annual review of the quality and safety of the care and support delivered to residents, as required by the regulations. As part of this review, the provider also conducted a detailed unannounced audit and produced a subsequent report every six months, which included an improvement plan based on the findings. The improvement plan identified several areas for improvement; however, for a number of these areas, the actions had not been completed from the previous six-month unannounced audit. It was also unclear from the plan who was responsible for ensuring the actions were implemented. For example, the plan did not identify who was responsible for reviewing incident reports for complaints and ensuring there was a consistent approach to recognising, recording and monitoring of negative resident interactions. The inspector found that these issues were still occurring in the centre, and there was no time bound plan in place to address these matters. From a review of incident reports, the inspector identified seven incidents since February 2019 of a safeguarding nature that should have been notified to the Chief Inspector but which had not been.

The inspector also reviewed how the provider was quality assuring the service between the providers' six-monthly unannounced visits. A schedule of audits had not been devised for the centre, and as a result, no local audits were being completed. Therefore, areas of concern or non-compliance with the regulations were not being monitored or addressed in a timely manner. The inspector identified there was a lack of procedures or protocols for the person in charge and local management team to follow for service monitoring to assist them in their roles and responsibilities.

The inspector reviewed the staffing arrangements in place. The provider identified this as an area of improvement in their communication with the Chief Inspector in October 2018, as the centre was not resourced with the full complement of staff required. While the provider had appointed additional staff into these posts, there remained a deficit of two whole-time equivalent posts due to a high turnover in staff. The provider detailed its efforts to the inspector to recruit and retrain new staff and stated that this had been difficult. The inspector also observed that interviews were scheduled and had taken place on the day of inspection. The same regular relief and agency staff were used to cover shifts in the interim.

Training had been provided to staff to support them in their role and to improve outcomes for residents. A training programme was in place which was coordinated centrally by the provider. Improvements were identified from the previous inspection, while training records showed that staff were up to date with mandatory and resident-specific training requirements. The inspector identified that the

supervision process had been strengthened with the introduction of a new supervision recording template with set agenda items. In addition, supervision meetings were proactive with a planned schedule of meetings for the year developed.

The registered provider had developed a contract of service provision agreement between the organisation and the resident. This document detailed the services and supports provided to residents. It clearly outlined the fees that they would be charged and any additional charges which they may incur. These agreements were signed by the resident and their representative, and also by a nominated person from the registered provider of the centre.

A complaints log was present within the centre with a record maintained of any complaints, comments and compliments received. A complaints policy was in place, which gave clear guidance for staff on how to deal accordingly with a complaint. The inspector became aware of one complaint during the inspection. The same complaint was previously made to the provider in February 2019 but had not at the time of the inspection been resolved.

Regulation 14: Persons in charge

The person in charge worked full time in this centre and had the educational and management qualifications required for the post.

Judgment: Compliant

Regulation 15: Staffing

There was a gap in necessary staffing arrangements to meet residents' assessed needs, equalling two WTE posts. The inspector viewed evidence of ongoing recruitment drives to address this deficit. The provider had ensured that there was continuity of care provided to residents through the use of the same regular relief and agency staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured that there were effective arrangements in place for staff supervision, and records were maintained of supervision meetings. Records reviewed indicated that staff were provided with training in areas such as fire safety, safeguarding, managing behaviours that challenge and the safe administration of medicines.

Judgment: Compliant

Regulation 23: Governance and management

While the governance and management systems in place identified gaps in the quality and safety of care delivered to residents, these concerns were not appropriately responded to. Issues that had been identified by the provider had not been addressed. Furthermore, the provider had not ensured that effective systems were in place for the oversight and the management of residents' finances and safeguarding concerns.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Suitable contracts for the provision of services were in place for each of the residents. It included the required information about the service to be provided, such as the fees to be charged and what is included in the fees.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider did not have adequate systems in place to notify the Chief Inspector when certain incidents took place as prescribed by the regulations. While some incidents of a safeguarding nature had been notified, the inspector saw records of similar relevant incidents which had not submitted to the Chief Inspector.

Judgment: Not compliant

Regulation 32: Notification of periods when the person in charge is absent

The Chief Inspector had been notified of the absence of the person in charge, as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were policies and practices relating to the management of complaints.
A complaints officer was clearly identified and systems were in place for complaints to recorded and followed up on. While the provider did act to address a complaint made, the actions taken did not demonstrate that the issue had been fully addressed.

Judgment: Substantially compliant

Quality and safety

While the inspector found some strong evidence that residents experienced evidence-based care, there was also evidence which demonstrated that further development was necessary to ensure regulatory compliance and the delivery of all aspects of care to a high standard. The inspector was satisfied that person-centred care was provided to meet residents' healthcare needs and the personal planning process ensured that residents' social, health and developmental needs were assessed. A review of the general welfare and development of residents found that there were appropriate supports in place for social integration and participation in the life of the community. The inspector identified that improvements were required in the management of residents' finances and safeguarding concerns. Practices relating to these matters needed significant development and review by the registered provider to ensure that appropriate systems were in place and were safe and transparent.

All staff had specific training in both Prader-Willi Syndrome and related food safety precautions as directed by international best practice. Safe choices, flexibility and independence, were promoted while at the same time providing residents with the food security reassurance required as part of the management of their condition. A safe living environment was also promoted. A dietitian visited the service monthly to discuss food preferences, monitor weights and make necessary dietary modifications. Staff supported residents to prepare their own individualised meals to

ensure residents' varied calorie requirements were delivered.

Personal planning arrangements ensured that each resident's needs were subject to regular review both annually and more frequently if their needs changed. In a sample of individual plans viewed, the inspector found that progress in achieving personal goals was well recorded. Many of the goals had been achieved, while others were in progress. Residents' goals included the promotion of community inclusion and skills development. Some residents were found to be attending day services, resource centres and workshops. Residents also engaged in a wide variety of activities and social roles, including attending annual conferences, art classes and bowling.

The inspector found that the identification and management of safeguarding concerns in the centre required review; in particular, the assessment of the negative impact of behaviours that challenge on other residents in the centre. Safeguarding plans that were submitted to the safeguarding and protection team, stated compatibility assessments would be completed. On review of these completed assessments, it was determined by the management team that there were no compatibility issues, when there remained ongoing compatibility issues. The inspector found internal processes used when managing allegations were not adequately overseen by the provider.

There were also incidents of psychological interactions between residents that were not identified as safeguarding concerns. Further system changes were also required by the provider to ensure safeguarding definitions and threshold were understood by all front line staff. For example, it was unclear what level of behaviour constituted a safeguarding incident, when this would need to be reported and the difference between a safeguarding concern and a complaint. As a result of this ambiguity, processes and procedures were not being followed in line with the organisation's own and health service executive (HSE) national safeguarding policies.

There was one restrictive practice in place which had been assessed in terms of risk and which had a clear rationale in place for its use. This restrictive practice had been reviewed on a regular basis by the staff team and by the provider's rights review committee. There was evidence that alternative measures were considered and trialled to ensure that the least restrictive practice possible was implemented. The inspector noted that there were systems in place and supports available to staff to address behaviours of concern in the centre. Positive behavioural support plans were in place for residents where required. It was unclear if positive behaviour support measures were adequately supporting residents with their assessed needs, in both supporting the individual and reducing any risk to others.

Some practices relating to the management and safeguarding of resident finances by the registered provider were found to be inadequate and required review. This was to ensure that the appropriate systems, policies and procedures were in place for a comprehensive account of expenditure. The provider's own recording and auditing systems did not sufficiently record or monitor the support provided to all residents in relation to their banking transactions. The auditing system needed to be

widened to include banking transactions to ensure that all residents had provided consent, and to protect them from the potential risk of financial abuse.

A centre-wide risk register was in place along with risk assessments relating to individual residents. The inspector reviewed individual risk assessments for the residents which contained a good level of detail, were specific to the resident and had appropriate measures in place to control and manage the risks identified. These included independent travel, smoking, respiratory failure and the self-administration of medicines. While staff present in the centre demonstrated a good understanding of risks present in the centre it was noted that the compatibility assessment did not accurately describe the risks identified during the inspection.

There was evidence of good practice regarding the management of medicines in the centre. There was a centre-specific policy for the procedures in place which guided staff in their practice. A sample of prescription and administration records were reviewed by the inspector. They contained the required information, such as the medicines' names, the medicines' dose and the residents' dates of birth. Records indicated that medicines were administered at the time stated on the prescription sheets. Appropriate storage facilities for medicines were also provided. It was also observed that the maximum dose of PRN medicines (medicines to be taken when required) weere consistently stated in the records. Residents were supported in their own choice of a pharmacist. Staff spoken with were familiar with and could demonstrate, the systems in place for the ordering, receipt, prescribing, storage, disposal and administration of medicines.

Regulation 13: General welfare and development

Residents were well supported socially and vocationally and had good levels of community involvement and activity. Residents were supported to take part in a range of activities that they enjoyed and which reflected their assessed needs, capabilities and interests. The inspector observed residents attending day services and social outings during the inspection.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents' specialised food and nutritional needs were assessed, planned for, supported and reviewed in the centre. Residents were supported to choose their own food, purchase ingredients, and were involved in preparing of their own meals, in line with residents' wishes.

Judgment: Compliant

Regulation 26: Risk management procedures

The centre had an established risk management system which in general reflected day-to-day service delivery. However, improvement was required to ensure that the system consistently reviewed and adequately described the control measures in place to manage risks.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider's medicines practices ensured that medicines was securely stored and administered to residents by suitably qualified staff. All prescribed medicine was subject to regular review into its ongoing suitability to meet the residents' assessed needs.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessment and personal plan was in place for each resident. These plans outlined the individual care needs of residents and guided practice for staff. There were social goals in place that were set out by key workers in conjunction with residents and were reviewed on a regular basis.

Judgment: Compliant

Regulation 6: Health care

Residents’ were supported by a multidisciplinary team and they had regular access to a general practitioner (GP) of their own choosing. Healthcare planning had also been devised to ensure that residents received continuity of care. The inspector saw examples of clear guidance provided to direct care relating to residents' healthcare needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Restrictive practices that were in use in the designated centre were appropriately assessed, monitored and reviewed in line with best practice. Efforts were also being made to reduce restrictive practices wherever possible. It was unclear if positive behavioural support measures were adequately supporting residents with their assessed needs.

Judgment: Substantially compliant

Regulation 8: Protection

The provider's safeguarding arrangements did not ensure that residents were protected from all possible forms of abuse. There was evidence that further knowledge and understanding was required in the systems for managing allegations, oversight of outcomes of allegations, and in providing ongoing supports to residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Graifin House OSV-0002636

Inspection ID: MON-0024749

Date of inspection: 03/09/2019

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There were 2 vacancies at time of inspection. • One permanent 39hr post has since been filled, staff member started on 1/10/19. • One permanent 39hr post advertised, interviews scheduled on 9/10/19. • Three regular relief staff and one regular agency staff member are currently in place to cover vacant post and staff leave.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Revised weekly and monthly audit system has been put in place in the service to improve oversight. This includes Team Leader / PIC review of daily recordings, service user support plans, RIVO incident, safeguarding plans and complaints. Audit folder has been set up to include the above recordings. This was completed on 23/9/19. • Going forward all actions identified through internal audits and HIQA inspections will be recorded on the organisation's action tracker database. The PIC will be responsible for assigning actions to staff and ensuring updates are provided on the action tracker until each action is closed. • A monthly report on actions related to non-compliances indentified in this inspection report will be completed by the Quality & Governance Directorate and supplied to the organisation's Senior Leadership and Board.	

• All actions reviewed from previous internal audits are completed. This was completed by 2/10/19.

• The importance of the recording and reporting of all incidents of negative peer to peer interactions was discussed with the staff team on 2/10/19.

• RIVO incidents were reviewed by PIC and required notifications sent to Chief Inspector and the HSE Safeguarding Team, this was completed by 3/10/19.

• Current compatibility risk assessments and plans will be reviewed with support from the Behaviour Therapist to ensure they accurately describe the risks identified during this inspection and clearly outline any existing and new control measures to mitigate these risks. This will be completed by 31/10/19. Detailed Compatibility Assessments to be completed by behavior therapist, this will be completed by 31/12/19.

• RehabCare have previously raised the issue of future needs of the residents due to their aging and due to compatibility issues with the HSE, most recently at a meeting on 03/09/2019. The HSE have advised that no additional funding will be made available. These needs will be raised again at a meeting to be held with HSE on 22/10/19.

• The PIC is going to liaise with relevant families to seek agreement that residents have control over their own finances with required support from the service. This will be completed 31/12/19.

• A local policy will be developed to guide staff practice in terms of steps to be taken when families have the primary access to resident's bank accounts.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• Review of notifiable incidents was completed with staff at team meeting on 2/10/19.

• RIVO incidents were reviewed by PIC and required notifications sent to Chief Inspector and the HSE Safeguarding Team, this was completed by 3/10/19.

• Going forward all incidents of a safeguarding nature will be recorded on RIVO and notified to HSE safeguarding team/ HIQA.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints policy in place and all complaints will be reviewed and followed up appropriately by PIC. This will be completed by 31/10/19.

• A review of complaints will form part of the new monthly audit, this will ensure the provider acts to address complaints made in a timely manner and issues are fully addressed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Going forward the provider will ensure the established risk management system in place is consistently reviewed and control measures are in place to manage risk. The new local monthly audit will provide additional oversight of risk issues.

• Current compatibility risk assessments and plans will be review with support from the Behaviour Therapist to ensure it accurately describes the risks identified during this inspection and clearly outlines any existing and new control measures to mitigate these risks. This will be completed by 31/10/19. Detailed Compatibility Assessments to be completed by behavior therapist, this will be completed by 31/12/19.

• The importance of the recording and reporting all incidents of negative peer to peer interactions was discussed with the staff team on 2/10/19.

New property/ property upgrade request to meet residents needs was resent to Newgrove Housing Association. This was completed by 3/10/19.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Behaviour support review to be completed with residents/ staff team and Behaviour Therapist, this will be completed by 31/10/19.

• Behaviour Therapist to meet with PIC on 17/10/19, and fortnightly thereafter until January 2020 to monitor incidents and the effectiveness of the behavior support plans and ensure changes can be made in a timely fashion.

• Behaviour support plan to be developed for one resident who previously didn't have one. This will be completed by behavior therapist-in consultation with the resident and staff by 30/11/19.

• Conflict management training to be provided for all residents by 31/12/19.

• Staff to promote positive relationships, identifying strengths and resident shared interests this will be completed by 31/10/19 and ongoing.

• RIVO incident review with ISM/ Behavior Therapist to identify trends and to monitor ongoing supports, this will be completed by 31/10/19 and ongoing.

• Detailed Compatibility Assessments to be completed by behavior therapist, this will be completed by 31/12/19.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Behaviour support review to be completed with residents/ staff team and Behaviour therapist, this will be completed by 31/10/19.

• Current compatibility risk assessments and plans will be review with support from the Behaviour Therapist to ensure it accurately describes the risks identified during this inspection and clearly outlines any existing and new control measures to mitigate these risks. This will be completed by 31/10/19. Detailed Compatibility Assessments to be completed by behavior therapist, this will be completed by 31/12/19.

• RehabCare have previously raised the issue of future needs of the residents due to their aging and due to compatibility issues with the HSE, most recently at a meeting on 03/09/2019. The HSE have advised that no additional funding will be made available. These needs will be raised again at a meeting to be held with HSE on 22/10/19.

• Review of notifiable incidents was completed with staff at team meeting on 2/10/19.

• RIVO incidents were reviewed by PIC and required notifications sent to Chief Inspector

and the HSE Safeguarding Team, this was completed by 4/10/19.

• Going forward all incidents of a safeguarding nature will be recorded on RIVO and notified to HSE safeguarding team/ HIQA.

• The PIC is going to liaise with relevant families to seek agreement that residents have control over their own finances with required support from the service. This will be completed 31/12/19.

• A local policy will be developed to guide staff practice in terms of steps to be taken when families have the primary access to resident's bank accounts.

• The local monthly audit will ensure that the PIC monitors all safeguarding concerns and conducts a trends analysis on a monthly basis to ensure going forward trends are picked up and addressed in a timely manner.

• Conflict management training to be provided for all residents, this will be completed by 31/12/19.

• Staff to promote positive relationships, identifying strengths and resident shared interests, this will be completed by 31/12/19 and ongoing.

• New property/ property upgrade request was resent to Newgrove Housing Association- 3/11/19.

• PIC will be completing "Implementing Safeguarding training" on 5/11/19.

• PIC to review safeguarding policy and procedures with all staff at team meeting- 30/11/19.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	09/10/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2019
Regulation 26(2)	The registered provider shall ensure that there	Substantially Compliant	Yellow	31/12/2019

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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	03/10/2019
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	31/10/2019
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.	Substantially Compliant	Yellow	31/12/2019

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	31/12/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/12/2019