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:	Beaufort Campus Units Area 2 - St. John of God Kerry Services
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	13 August 2019
Centre ID:	OSV-0002905
Fieldwork ID:	MON-0024864

About the designated centre

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

The service was based on a large campus in proximity to a rural village. The service provided residential care for up to 43 residents who had moderate or severe intellectual disability. Some residents had a dual diagnosis and significant medical conditions. Residents were male and female and five of the residents availed of shared care and respite. Many of the residents had lived in the designated centre since they were young children. Accommodation was in 10 separate houses or units / apartments. Three residents had individual apartments. Between two and eight residents resided in each house. All accommodation was at ground floor level. The campus grounds were generally well maintained. The service was nurse led and the staff team comprised of nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

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 August 2019	09:00hrs to 20:00hrs	Michael O'Sullivan	Lead
13 August 2019	09:00hrs to 20:00hrs	Lucia Power	Support

Views of people who use the service

The inspectors met with and observed many of the 39 residents during the course of the inspection. Inspectors attended some houses on three separate occasions, at different times of the day. Many residents did not communicate verbally.

The inspectors observed that staff were very caring towards the residents and some staff told the inspectors that if there was more staff available they could provide individualised supports as currently they focus on group activities. The inspectors reviewed each of the meaningful day boards and the activities scheduled were primarily campus based or drives in the community. The inspectors spent time in each of the units and observed the practice and culture to be institutional in nature. There was a communal laundry basket in each unit and when the inspectors asked why residents did not have their own laundry baskets, it was noted this was never considered before. The inspectors asked some staff if consideration was ever given to doing some skills based training with residents around laundry skills, the responses varied from the residents not been able to partake in this activity or not enough staff to support the resident.

A number of the units had a locked gate entering the residence and limited external activities for the resident to partake in within the surrounds of their home. The units also had locked kitchens and access was restricted for a number of residents, this was not reviewed in the context of all residents rights.

The inspectors observed residents sitting in communal areas with limited individualised supports and where staff were doing their best to meet their needs it was evident to the inspectors that staff supports in place did not meet the needs of the residents so as to ensure a meaningful day and quality of life for all residents. The inspectors did not observe a culture of promoting resident independence as there was no evidence of skills training within the home to support residents have involvement or control over their lives. Many residents were non verbal but from observation the inspectors noted their day primarily focused on campus based activities that were limited as the provider did not demonstrate a more independent person centred approach.

The inspectors also observed that residents activities on the day of inspection was curtailed due to staff been redeployed to other areas. The feedback from relatives in the registered providers annual review was noted by inspectors, particularly the requests for more staff, more activation and more social activities.

Capacity and capability

The inspectors found that the quality of accommodation was mixed for some residents. Some residents had suitable space and bedrooms that were well presented while some did not. Some units were observed to be not suitable to meet the assessed needs of the number of adult residents they accommodated. The provider had not complied with the action plan from the previous inspection to create additional built space for residents in two units by October 2018. A revised plan and time line to fulfill this action by 2020 was proposed by the provider.

The designated centre comprised of 10 separate units all located on a large campus. Three of the units were individual apartments that accommodated one resident and one unit accommodated two residents - one resident who was convalescing post hospitalisation and one who was in the process of transitioning into the unit on a full-time basis. One unit accommodated five residents and also had two residents who attended for shared care / respite. The inspectors observed that the premises available to these residents were suitable to meet the residents assessed needs. The premises were well maintained, decorated and clean.

The other five units were in need of repair and remedial works both internally and externally. While the decorative state of one unit that accommodated six female residents was satisfactory, the other four units were in need of significant painting. None of these units had adequate space or suitable storage facilities, wash rooms were used to store hoists, laundry and other items. Communal spaces for residents were limited and were observed to be overcrowded. Some residents shared bedrooms and had insufficient space. Some single occupancy bedrooms were not sufficient to accommodate residents with limited mobility who were wheelchairs users. Private space was limited to bedrooms and there were no facilities specific to facilitating visitors.

The statement of purpose for the service was reviewed by inspectors on the day of inspection. The information required by regulation was factually correct with the exception of floor plans and drawings that were corrected on the day and presented to the inspectors. Statements contained within the document in relation to privacy and dignity, consultation with residents, social activities and visiting arrangements were reviewed in the context of this inspection and these findings are referred to separately.

The registered provider had undertaken a six monthly unannounced inspection of the safety and quality of care in the designated centre. Many issues observed and identified by the inspectors on the day had been identified by the registered providers quality advisers in the unannounced inspection of June 2019 and an action plan had been compiled for each unit. The action plan had yet to be implemented. There was evidence that the registered provider had some plans in place to achieve compliance with regulations. The inspectors observed that the planned actions, if delivered, would not ensure regulatory compliance for all residents.The annual review conducted in 2018 did not effectively cover a review of

the quality and safety, or the capacity and capability of the designated centre and how this would inform continuous improvement. It was not demonstrated that the registered provider was ensuring that the designated centre was resourced to effectively deliver care and support in accordance with the statement of purpose provided to the Health Information Quality Authority - HIQA.
Inspectors observed that the designated centre did not have sufficient management systems in place to ensure the safe delivery of service, appropriate to residents complex needs. This was contributed to, in part, by the number of residents accommodated and the total amount of units in one designated centre. There was no evidence to suggest that learning from a prior inspection on the campus, had disseminated throughout the service.

The registered provider had in place an actual and planned staff roster. While all residents appeared to have the same level of needs and required supports, the allocation of staff ratio to residents differed from unit to unit. Some residents had one to one staffing in place while some units had two or three staff in place for six, seven or eight residents. Inspectors observed that rostered staff were moved to another designated centre during the course of the 12 hour day. The number of staff allocated at night time across the ten units was eight plus one floating member of staff to assist all of the units. In addition there are a minimum of two additional floating staff on campus at night to respond in the event of an emergency.

Regulation 15: Staffing

The registered provider did not ensure that the numbers of staff were appropriate to the assessed needs of the residents.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure that the designated centre was adequately resourced to ensure the effective deliver of care and support in accordance with the statement of purpose.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not contain all of the necessary information as

required by schedule 1.

Judgment: Substantially compliant

Quality and safety

The inspectors spent a greater proportion of the inspection observing residents and staff during the course of a 12 hour shift. While there were substantial written records available to inspectors on the day, an equal proportion of time was spent observing resident and staff interactions. Many residents observed were young, active and had non verbal communication. Staff were observed to be very gentle and kind in their interactions with residents. Staff were also observed in some units to be very busy, but all clearly demonstrated concern for the residents they supported. Overall the inspectors observed a service that delivered basic care to residents that in many instances was not person centred or individualised. The emphasis on resident safety was extremely restrictive and not in keeping with the location, space and grounds available to the provider. The provision of a meaningful day to residents was determined and limited by staff resources and the institutional physical environment. Inspectors did not observe skills training to promote greater independence for residents, did not see residents involved in meal planning, basic household chores or engaged in any activity to suggest they were involved in the running of their own home or their own lives.

The registered provider had ensured that all units were subject to a review by a fire and safety consultant and a report of fire and safety deficits was awaited by the registered provider. Inspectors noted that fire extinguishers, fire alarm systems and emergency lighting had all been certified by a suitably qualified contractor within the current year. Each resident had a personal emergency evacuation plan that was up to date. Two units had recorded fire drill evacuation times that were not within acceptable time frames and many of the units had fire doors that did not have a required door closure. Staff did complete daily and weekly fire checks. In one unit a kitchen door was observed to be held open by a hook and exposed electrical wiring was observed at ceiling level in the corridor. Two fire drills also recorded the refusal of a resident to leave the unit while in other instances it was noted that the resident sought to access the building during the drill. The floor plans in some units to advise staff in the event of a fire were out of date, did not reflect current room designations or the resident occupying them. Based on the assessed needs and the high level of staff support required by each individual resident, the inspectors were not assured that in the event of a fire, all persons in the designated centre could be evacuated. An urgent compliance action plan was requested of the provider in relation to these matters. The inspectors noted that similar findings were recorded in another designated centre, located on the campus, within the current year. There was no evidence to suggest that learning from that inspection had disseminated throughout the service.

There was evidence that the provider had in place a good level of healthcare for each resident and medical treatment as required was facilitated. A general practitioner attended the service on a regular basis or when required. The registered provider had in place a team of allied health professionals that residents had access to.

The inspectors reviewed the individual care plans of six residents. Each resident had an individual care plan that was subject to annual review. In many instances there was evidence of goals continuing to be brought forward year on year. Where a resident was unable to achieve a goal due to health or physical constraints, the goal was left in place. There was no evidence of refocusing or defining a new goal. Many goals were related to house or campus based activities.

Each resident that required a behavioural support plan had one in place. The positive behavioural support plans were comprehensive, regularly monitored and reviewed from a documentary perspective. A number of residents were engaged in what was documented as self injurious behaviour which resulted in significant injury to two residents in particular. These injuries had the potential to be life altering and life limiting. The provider had a policy for identifying triggers for behaviour, data analysis of behaviours, protocols and reactive strategies and staff training. There was no evidence that antecedents of a lack of a meaningful day, life style, preferences, social goals, boredom, overcrowding and staffing levels, were matters considered. Some residents had been observed to be sitting in units with little stimulation or activity. Senior managers did inform inspectors on the day of exploratory plans to introduce a dedicated community activation programme for some residents.

Some of the residents attended an on site day service for activities and recreation. Inspectors noted that residents in units with the greater numbers of rostered staff, had more accessibility to the day service. Staff demonstrated an understanding of what constituted a meaningful day for residents but in many instances, the resident's day was defined by a singular activity. Staff numbers determined whether an activity was campus based or out in the wider community. Staffing numbers also determined whether a drive off campus involved alighting from the vehicle or not. In many instances the default activity was a walk on campus. Inspectors observed limited opportunity for the majority of residents to avail of activities in the community. Staff spoken to on the day were very much of the view that most residents required two staff to facilitate community activities. Inspectors observed that residents who had set goals to attend community events, did not manage to achieve the goals as a result of documented staff shortages, staff allocated to another unit or staff breaks running late.

Of four individual care plans reviewed, there was no evidence that the resident had a choice or were consulted in regard to who they lived with. Inspectors observed restrictive practices in place that significantly impacted on all residents in a unit, where the actions or concerns pertaining to one resident meant the restrictive practice was applied to all.

Innovative, high tech solutions have been trialled by the registered provider in one

unit, but still amounted to restrictive practices being applied to all residents. The nature of some security measures applied were custodial, fostering a greater dependence on staff. Staff were observed to be kind and respectful to residents, however the environment and support was institutional in nature. The privacy and dignity of residents were not upheld in how residents files were on open display within some units, a notice on a notice board seeking clothing for residents, items discussed in relation to residents care at residents' house meetings and the lack of access to basic facilities. These included no access to individual laundry baskets, no access to toilets and toilet paper. Residents continued to share bedrooms. Not all residents were observed to maintain control over their own clothes, and bed linen was shared in some units. The registered providers six monthly unannounced visit highlighted the withdrawal of funds on behalf of a resident without evidence of the resident's consent.

The registered provider had a current risk management policy in place. The inspectors found evidence of written referrals and communication to the human rights committee in relation to restrictive practices that had been risk assessed. There was no correlation between the level of risk identified and the restrictive practices in place to reduce the assessed risk. Some committee meeting notes were vague and some practices were noted as not for the committee's consideration. In some instances, the committee requested positive behavioural support plan updates in advance of considering the review of a restrictive practice. Consequently, restrictive practices were not subject to review. Some practices were awaiting referral to the committee. The inspectors were not assured that the provider had an effective arrangement in place to ensure that risk control measures and restrictive practices were proportional to the risk identified and that the adverse impact of such measures on the quality of the resident's lives was considered.

Regulation 11: Visits

The registered provider did not ensure adequate facilities for residents to receive visitors.

Judgment: Not compliant

Regulation 12: Personal possessions

The person in charge did not ensure that residents were supported to manage their own laundry.

Judgment: Not compliant

Regulation 13: General welfare and development

The registered provider did not ensure that residents were provided with the supports and care in relation to their assessed needs and wishes.

Judgment: Not compliant

Regulation 17: Premises

The registered provider did not ensure that the premises was designed and laid out to meet the assessed needs of residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place, however, the provider did not ensure that risk control measures were proportional to the risk identified and that any adverse impacts such measures might have had on residents quality of life, were considered.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not have adequate arrangements in place to contain fires and adequate evacuation arrangements were not in place.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The registered provider had in place a personal plan for each resident that was subject to review.

Judgment: Compliant

Regulation 6: Health care

The registered provider had appropriate healthcare plans in place for each resident.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge did not ensure that the least restrictive practice was used for the shortest duration.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider did not ensure that residents were consulted and had the choice to control their daily life.

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 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Beaufort Campus Units Area 2 - St. John of God Kerry Services OSV-0002905

Inspection ID: MON-0024864

Date of inspection: 13/08/2019

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

The Registered Provider is engaged with the Statutory Funding Agency to address the legacy issues relating to staffing levels within the congregated setting and has submitted comprehensive proposals on Funding required to the statutory authority. The Registered Provider has submitted an updated proposal to the Statutory Funding Agency for additional staffing to ensure the numbers of staff are appropriate to the assessed needs of residents and is in ongoing communication to progress same. Proposal submitted on 13/08/19.

• A business case has been submitted to the HSE with a request to fund an increase in staffing to develop a community integration programme to support residents in the DC with community activity.
Completed 03/09/2019
• The registered provider will be advised by the Statutory Funding Agency of the outcome of this business case at year-end.
Completion date:31/12/2019

• SAM's training is planned to increase the availability of suitably qualified staff by 12 across the Designated Centre to support residents access community based activities on a daily basis.

• Update: 4 staff have completed SAMs training on the 22/08/2019 and the remaining 8 staff are scheduled for the last quarter of 2019.
Completed 31/12/2019

• The registered provider will review the current staffing configuration to extend the role of the Social Care Worker within the Designated Centre and to increase the availability of appropriate skill set to support with person centred planning and practice development.

• The registered provider in consultation with the PIC will re-assign the current available skill mix across locations i.e. nursing/social care and care staff based on resident's needs.
Completion Date: 31/12/2019

• Update: The registered provider is implementing an ongoing recruitment strategy to fill existing vacancies within the Designated Centre, which will be in keeping with the revised skill mix allocation and interviews have taken place in September and October with further interviews scheduled to take place up to 20/12/2019.
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
23 (1) (a)
• The Registered Provider is implementing an ongoing recruitment strategy to fill existing vacancies within the Designated Centre.
• Update: Interviews have taken place in September and October to support recruitment process and with further interviews scheduled to take place up to 20/12/2019
Completion date:30/03/2020

23 (1) (c)
• The Registered Provider in consultation with the PIC will review the existing practice of cross Designated Centre cover onsite and develop a local procedure in relation to this practice incorporating emergency situations.

Update: Initial meeting held with local frontline managers on the 02/10/19 as part of this process
Completion date:30/11/2019

• The Registered Provider, in consultation with the PIC, will review the existing governance structure within the Chalets. This review will assess the current use of frontline staff and implement recommendations to ensure an appropriate plan is in place that results in frontline resources being based on the current WTE and same is allocated to the maximum benefit of all residents.
Completion date: 31/12/2019

23 (1) (d)
• The PIC will commence the consultation process with residents and family representatives on the 1/11/2019 in preparation for the collation of the annual review for 2019.
Completion date 31/12/2019

• The PIC will complete the Annual Review for the current year 2019 to ensure that it is conducted in a manner that effectively reviews quality and safety as well as the capacity and capability of the Designated Centre. The Annual Review will be completed in line with HIQA guidelines.
Completion date: 30/03/2020

• The Registered Provider and PIC will commence Supported Self Directed Living information sessions as part of the training calendar to support practice development within the Designate Centre
Completion date: 31/01/2020

• The Registered Provider will ensure that learning from Inspections on campus is communicated and discussed at bi-monthly campus quality meetings.

• Update: October 1st 2019 campus quality included both Designated Centre management representatives and inspection finds reviewed for both DCs. This will remain a standing agenda item in this forum
Completion Date: 28/02/2020
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
03 (1):
• The registered provider has updated the statement of purpose to ensure floor plans and drawings are up to date and accurate. The skill mix outlined within the statement of purpose
Completed 3/10/2019

Regulation 11: Visits	Not Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
11 (1) 11(3) (a)
• The Registered Provider will provide an additional conservatory to two residential areas on site.
Completion date: 30/06/2020

• The Registered Provider will reduce the number of residents in one location to three resulting in the availability of increased private areas for the remaining three residents.

• Update: Recruitment in progress and interviews have taken place to identify staff to support the transition of the resident
Completion date: 28/02/2020

• The Registered Provider will upgrade one linked location to provide an alternative additional space to residents for both private and communal activities in consultation with the Occupational Therapist.
• Update: Occupational therapist has reviewed the area in consultation with the team and plan in place in relation to design requirements. Funding has been agreed to progress the project and same has commenced with residents input.
Completion date: 30/12/2019
11 (3) (b)
• The Registered Provider will upgrade additional locations within the campus to be available to residents and visitors i.e. dining room, Sitting room in the main building on the campus grounds
Completion date: 31/12/2019

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
12 (1)
• The management of finances is discussed with family members as part of the individual planning process; in the case outlined in the body of the report this occurred on the 05/04/2019.
• Each resident has an up to date individual financial passport in place and same will continue to be reviewed on an ongoing basis to ensure the procedure in place to manage their finances is clearly outlined.
Completed:30/09/2019
12 (3)a

• The PIC in conjunction with maintenance staff will conduct a visual audit of the premises and establish any additional available spaces that can be utilised for the

purpose of storage for the residents' personal possessions.
Update: Completed 8/10/2019

• A plan will subsequently be put in place as part of the maintenance schedule in consultation with the Capital Expenditure committee.
Completion date: 31/12/2019

12 (3) (b)
• Residents are currently being supported to have individual laundry baskets for their own personal use.

Update: Residents have been supported to source laundry baskets for their personal use. The remaining residents who wish to avail of this option are currently being supported.
Completion date:31/10/2019

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
13 (1)
• The registered provider will complete the recruitment of a Community Transition Coordinator. This role will support residents and teams in promoting community participation opportunities in line with their will, preferences, choices and evidence based practice.
Completion date: 30/11/2019
• Update: Community Transition Coordinator has been recruited and is due to commence on the 23/10/2019. The post holder will complete an induction within the designated centre during November 2019

• The registered provider in consultation with the Community Transition Coordinator will develop a strategy that will educate staff in relation to supporting individuals in community participation and person centred models of support
Completion date:31/03/2020
13 (2) (a)
• The registered provider will increase the availability of transport in the DC by one vehicle.
• Update: Funding has been identified for two additional vehicles to be purchased to support community based activity and these are currently being sourced
Completion date: 31/12/2019

• The CNM2 managers in consultation with the Occupational Therapist will review the current implementation of Using Your Environment goals for each resident currently assessed; identify barriers to the achievement of goals to support resident's active

participation in their home and any deficit in documentation.
Completion Date: 31/12/2019

• The CNM2 managers will promote and monitor the implementation of goals on Using Your Environment to enhance resident's independence and the provision of active support in each location.
Completion Date: 31/12/2019
• Each residential area will identify one staff member to co-ordinate and plan preferred person centered activities for residents within each location.
• Update: Each location has identified a minimum of one activity coordinator within the team to co-ordinate preferred person centered activities for residents
Completed:01/10/2019
• The activity coordinators will be prioritised for information sessions in promoting community participation opportunities in line with evidence based best practice models.
Completion Date:28/02/2020
13 (2) (b)
• The CNM2 Managers in consultation with keyworkers will ensure each residents plan clearly outlines the resident's preference in relation to preferred activities.

• The CNM2 Managers will oversee that each resident's weekly schedule is monitored to ensure residents have access to preferred activities
Completion date:31/10/2019

• Keyworkers in consultation with project leader will receive mentoring in developing meaningful goals as part of developing person directed plans.
Completion date:30/03/2020

• Staff members will receive mentoring in the standard required to record residents' activities and the accurate monitoring of these activities.
Completion date:31/12/2019

• The PIC in consultation with the CNM2 managers will introduce a monitoring system to ensure residents community based activities are accurately monitored and plans are put in place within the available resources in relation to residents where a concern is identified. This information will be reviewed at programme manager and PIC meetings.
Completion date:31/12/2019

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
17 (1) (a)
• The Designated Centre is closed to new admissions.
Completed

• The registered provider is currently working jointly with the HSE in the purchase of an additional house in the community to support residents from this Designated Centre who have identified their wish to move to a community setting. CAS application is currently being progressed with a view to securing the property.
Completion date:31/08/2020

Note: (Planned move of residents will be dictated by the progress of the purchase of property, completion of adaptations to property and completion of recruitment).

• One bathroom will be extended to provide additional room to support changing needs of residents.
• Update: Major works and adaptations have been complete and final décor is in progress
Completion date:31/10/2019

• Multi occupancy rooms are no longer reallocated to another resident in the event of a vacancy.
Completed
• Reference actions 11 (1) 11(3) (a) 11(3) (b)

17 (1) (b)
• The Registered Provider implements a planned schedule of maintenance on an annual basis.

• The Registered Provider will continue to prioritise and plan maintenance in consultation with the Capital Expenditure Committee on a quarterly basis. Schedule for 2020 to be developed.

Completion date:30/12/2019
17 (1) (c)
• A rolling schedule of painting and decorating is in place for the Designated Centre. The PIC in consultation with the CNM2 managers will prioritise locations for decorating for the last quarter of 2019.
Completion date:31/10/2019

• Each keyworker will be requested to review residents' rooms and bring forward the residents' wishes to CNM2 managers for consideration and to be included in the planned maintenance schedule.
Completion date:31/12/2019

• A schedule for the redecoration of resident's rooms will be in place for 2020.
Completion Date: 31/12/2019
17 (7)
• The registered provider has consulted with a suitably qualified architect who has confirmed they will construct an additional conservatory to two residential areas on site.
Reference also 17(1)(a) 17(1)(b) 17(1)(c)
Completion Date: 30/06/20

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
26 (1) (e)
• The PIC and CNM2 Manager for each location will review the existing restrictive practice log for each location to ensure all restrictive practices are captured.

• The log will clearly identify locked areas, restrictive access to personal possessions and restricted access to basic hygiene products.
Completion date:30/11/2019

• The PIC and CNM2 managers will link each restrictive practice to the risk assessment and risk descriptor where the practice is identified as a control measure.

• Where the restriction is not proportionate the PIC and CNM2 managers will put a plan in place to reduce/remove the restriction as appropriate
Completion date: 30/12/2019

• The multi-disciplinary risk forum will validate the remaining restrictions in the context of the risk descriptor that they relate to.
Completion date: 31/01/2020

• Based on completion of the above actions the PIC in consultation with the CNM2 managers will refer all remaining restrictions for review by the Rights Review Committee.
Completion date :31/01/2020

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
n the course of HIQA Inspection in 2019 a compliance issue was raised in relation to regulation 28 fire precaution and in particular the potential risk to the resident and staff member during a fire in the residents home and the safe evacuation of all occupants.

The Service has significant controls in place in relation to fire safety these include the following control measures:
• Fire Safety Register in place

• Staff Fire safety checks on equipment. Fire Alarm and Escape Routes checked daily.
• External testing of Emergency Lights and Fire-Fighting equipment.
• Staff are trained in Fire Safety.
• Emergency plans and associated guidelines are in place.
• Personal Emergency Evacuation Plans in place.
• Fire Safety Training Drills practices quarterly.
Evacuation drills took place in the Designated Centre on 17/06/2019. Following these drills one additional staff has been assigned to the Designated Centre at night to support evacuation in the event of fire.
The Provider has undertook an appropriate risk assessment to identify the appropriate additional control measures required in the interim to reduce the current level of risk and the works to achieve compliance with current legislation. The Registered Provider is actively monitoring and reviewing the implementation of the additional control measures identified.
Compliance Plan:
Regulation 28 (3) (a)
• The Registered Provider has submitted an additional Report to the Regulator relating to Fire Precautions on the campus.
Completed: 06/09/2019
• The Fire Safety Consultant will complete a Risk Assessment for the Designated Centre and Action Plan to be developed.
Completion date:14/10/2019
• Update: Registered Provider has received a copy of the completed risk assessment from the competent fire consulted and once reviewed will furnish same to the regulator
Completion date:18/10/2019
• The Provider will develop an Action Plan with timelines once this process is complete.
Completion date:31/12/2019
• Update: The registered provider has met with the architect and quantity surveyor who are currently developing a scope of works based on the fire consultants risk assessment

• Any remedial works required to ensure adequate arrangements for the containment of fire will be completed.
Completion date: 30/03/2020
• An audit has been completed on Fire Doors. All doors identified as requiring replacement of intumescent strips have been carried out.
Completion date:06/06/2019
• A total of 46 doors have been identified as potentially requiring door closures. These works are currently being costed and scheduled for implementation.
Completion date 31/03/2020
• One cross corridor door requires an additional seal at the base in one location, this has been ordered and same will be retrofitted.
Completed: 20/09/2019

Regulation 28 (3) (d)
• The Registered Provider has reviewed staff levels at night following June 2019 fire drills and has increased the staff available in this DC by one.
Completed 24/06/2019

• The Registered Provider has consulted with an external Fire Safety Adviser to develop

individual unit evacuation plans and guidance for each location within the DC.
Completed 31/08/2019

• The Registered Provider has complete additional night time drills based on the evacuation plans completed in consultation with the external fire safety advisor in areas with protracted evacuation times to ensure adequate support is available.

Completed 31/08/2019
Regulation 28 (4) (a)
• The Registered Provider will install French doors from one bedroom to the outside to ensure an improved evacuation time for the current resident should the risk assessment by the fire consultant validate the need for same and the architect concurs that this is a viable option in the location; a ski sheet is currently in place for this resident.
Completion date:30/03/2020
Update: A Competent Fire Consultant has completed a risk assessment on this location and has determined "Ski sheet evacuation has ensured the corridors are sufficiently wide for evacuation". The fitting of French doors is no longer required and the consultant has outlined that "the building is provided with reasonable arrangements for means of escape for disabled people".
Completed 10/10/2019
• The Registered Provider in June 2019 commenced an accelerated fire safety training programme by a competent external fire safety company to provide the required mandatory training to staff in the DC. Staff have commenced this training.
• Update: 67 staff have been trained and the remaining staff are scheduled in the last quarter of 2019
Completion date: 31/12/2019
• Fire safety training by an external competent facilitator will form part of the annual training calendar to maintain staff training levels within the required 24 months.

Completion date 31/12/2019

Regulation 28 (5)
• The Registered Provider in consultation with an external fire safety adviser has developed an individual fire action notice for each individual location. These will be displayed in each area to advise all staff of the actions required in the event of fire alarm activation.
Completed 19/08/2019

• The existing Floor Plans will be reviewed to reflect the current configuration of each unit and be readily available within the DC.
Completed 19/08/2019

• Completion of the Risk Assessment by the relevant Fire Consultant will be an integral part of identifying additional actions to enhance fire precautions on the campus in Beaufort. This risk assessment will be completed on 11/10/2019
Completed
• Update: risk assessment has been completed and submitted to the registered provider

on the 11/10/2019.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
7 (5) (a)
• The PIC in consultation with the behaviour department will continue to review trends in relation to behaviour incidents and identify all potential triggers that can be alleviated by the PIC.
Completion date 30/03/2020
• Update: The PIC in consultation with behaviour support department has identified 3 priority residents within the designated centre for review of their multi element behavior support plan. This process is underway as part of the Longitudinal Multi Element Behavior Course currently being facilitated by the Callan Institute on site
Completion date 28/02/2020

• A Further 4 Residents have been identified for data analysis of behavior incidents with the Callan institute to identify antecedents.
Completion date: 31/12/2019
7 (5) (b)
• The registered provider will complete a restrictive practice self-assessment for each person's home and develop a quality improvement plan based on the outcome of same.
Completion date:31/12/2019
• An Action Plan will be developed following completion of the assessment to ensure the least restrictive practice is in place within existing resources.
Completion date:31/12/2019

• Restrictive practices identified in the management of risk will be monitored as part of the Quality and Safety Committee. The log of restrictive practices will be furnished to the committee for review as part of this process
Completion date:30/12/2019
7 (5) (c)
• Rights Restoration Plans will be prioritised and put in place in relation to each location for restrictions identified.
Completion Date: 31/01/2020

• The Registered Provider will install assistive technology in one location for two residents in the location to reduce the impact of the current restrictions in the house due to residents behavior support needs.
Completion date: 31/12/2019

• The PIC in consultation with the Occupational Therapist will review the implementation

of this system following installation to determine the suitability of extending to all residents based on their individual needs
Completion date 30/01/2020

• A review of residents' behavior support plans will take place in relation to individuals who engage in Self Injurious Behavior that have been prioritised as category one through multi-disciplinary review.
Completion Date: 31/12/2019

• The resident highlighted as having life altering behavior will continue to be reviewed on a quarterly basis with the multi-disciplinary team.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: 9 (2) (a)

• The Person Centred Planning meeting will document rights restrictions in place and this information will be provided to the residents' representative. This will commence as planning meetings are scheduled over the annual period.
Completion date:30/11/2019
9 (2) (b)
• The registered provider will facilitate restrictive practice and rights awareness to key management personnel in the Designated Centre
Completion date:31/10/2019

• The Registered Provider has requested a full review of Rights documentation in relation to residents in the Designated Centre.
Completion date:31/10/2019

• This registered provider will link with the chair of the rights committee and develop recommendations in relation to governance and management of the referral process and identify actions to any issues identified.
Completion date 15/12/2019
• The PIC will include questions in relation to Residents rights as part of the consultation process with residents and their family representative for the annual review.
Completion date 31/12/2019
9 (2) (e)
• The review conducted by the registered provider will include any rights referrals identified that have not been responded to by the Rights Review Committee. The PIC will follow up with same to obtain a response if the restriction is still in place.
Completion date:31/01/2020
9 (3)
• Appropriate storage space will be identified and put in place to allow secure storage of

resident files.

• Update: The PIC in conjunction with maintenance staff has conduct a visual audit of the premises and any files stored in communal areas have been removed or alternative secure area provided to store same
Completed: 9/10/2019
• As part of the audit additional areas have been identified to be upgraded to provide additional secure storage of resident's information within locations. A planned schedule of works will be developed in consultation with the maintenance department
Completion date:31/12/2019

• All notices relating to requests for clothes donations have been removed.
Completed 19/09/2019

• Residents meeting agenda will be revisited to ensure residents meetings are related to the resident issues and support their participation in the planning of Designated Centre activities with an emphasis on supporting and involving residents in the running of their own home and their own lives.
Completion date:30/11/2019
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

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 11(1)	The registered provider shall facilitate each resident to receive visitors in accordance with the resident's wishes.	Not Compliant	Orange	30/06/2020
Regulation 11(3)(a)	The person in charge shall ensure that having regard to the number of residents and needs of each resident; suitable communal facilities are available to receive visitors.	Not Compliant	Orange	30/06/2020
Regulation 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident's room, is available to a resident in which	Not Compliant	Orange	31/12/2019

	to receive a visitor if required.			
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/09/2020
Regulation 12(3)(a)	The person in charge shall ensure that each resident uses and retains control over his or her clothes.	Not Compliant	Orange	31/12/2019
Regulation 12(3)(b)	The person in charge shall ensure that each resident is supported to manage his or her laundry in accordance with his or her needs and wishes.	Not Compliant	Orange	31/10/2019
Regulation 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.	Not Compliant	Orange	31/12/2019
Regulation 13(1)	The registered provider shall provide each resident with appropriate care	Not Compliant	Orange	31/03/2020

	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.			
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	28/02/2020
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	28/02/2020
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	30/03/2020
Regulation 17(1)(a)	The registered provider shall	Not Compliant	Orange	31/08/2020

	ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
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	30/12/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/12/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2020
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	30/03/2020
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	31/12/2019

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/03/2020
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	31/01/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and	Not Compliant	Red	31/03/2020

	extinguishing fires.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	31/08/2019
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Red	31/12/2019
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Red	11/10/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing	Substantially Compliant	Yellow	03/10/2019

	the information set out in Schedule 1.			
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	30/03/2020
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	30/12/2019
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/03/2020
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature	Not Compliant	Orange	30/11/2019

	of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/12/2019
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	31/01/2020
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	Not Compliant	Orange	31/12/2019

	personal care, professional consultations and personal information.			