Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	L'Arche Ireland - Dublin
Name of provider:	L'Arche Ireland
Address of centre:	Dublin 13
Type of inspection:	Announced
Date of inspection:	19 and 20 June 2019
Centre ID:	OSV-0003418
Fieldwork ID:	MON-0022528

About the designated centre

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

L'Arche Dublin is a community based service in Co. Dublin providing care and support for seven residents over 18 with an intellectual disability. The centre is located close to the centre of a seaside town. The centre comprises of two houses. The first house consists of 10 bedrooms, two of which are ensuite. It also contains two offices, a living room, sun room, kitchen come dining room, living room, pantry, laundry room, visitor's room, two bathrooms with bath and shower facilities. There is a large front and back garden with two wooden structures used as an office and an art room/training room. The second house is close to the first and contains seven bedrooms, four bathrooms, a living room, kitchen/dining room, laundry and office. There is also a back garden with a building which is used for visitors. Both houses are close to a variety of local amenities such as shops, pubs and churches. There are good local transport links close to the centre and residents have access to vehicles in the centre to support them to access activities and venues in line with their wishes. Residents are supported on a 24 hour basis by a staff team consisting of a person in charge, deputy team leaders, nursing staff, social care workers and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
19 June 2019	09:30hrs to 17:25hrs	Marie Byrne	Lead
20 June 2019	09:30hrs to 15:50hrs	Marie Byrne	Lead
19 June 2019	09:30hrs to 17:25hrs	Valerie Power	Support
20 June 2019	09:30hrs to 15:50hrs	Valerie Power	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet six of the seven residents living in the centre on the day of the inspection. They had the opportunity to speak with and spend some time with four of the residents. A number of residents spoke to the inspector about their hobbies, interests and achievements. They described what it was like to live in the centre and how they were supported by staff to spend their time engaging in activities of their choosing. Each of the residents told the inspector that they felt safe in their home and knew who to go to if they had a complaint.

From reviewing documentation and speaking with residents and staff it was evident that residents were actively participating in their local community. They had access to vehicles to support them to do this. Some residents who spoke with the inspector described how important their day service was to them and how they liked to actively participate in their local community. They described how important their weekly visit to a local venue was as they liked to take part in activities there in line with their interests including; music, dancing, baking, art and the use of puppets. They described recent holidays and other events they had taken part in.

The seven residents living in the centre, or their representatives completed satisfaction questionnaires prior to the the inspection. Some residents were supported to complete the questionnaires by staff in the centre. The feedback in these questionnaires was mostly positive. Residents and their representatives were particularly complimentary towards food and mealtimes, visitors, residents' rights, choice of activities, and staff support in the centre. One resident indicated in their questionnaire that they would like bigger doors to improve accessibility for their wheelchair.

Capacity and capability

Overall, the inspector found that the registered provider and person in charge were monitoring the quality of care and support for residents. They were completing regular audits including the annual review of quality of care and support in the centre and six monthly reviews by the provider or their representative.
These reviews were identifying areas for improvement in line with the findings of this inspection. However, a number of actions from these reviews were not being progressed in a timely manner such as maintenance and other works to premises to ensure it was fully accessible for residents.

There were clear management systems and structures in place and staff had clearly defined roles and responsibilities. The annual review of care and support was

recognising areas for improvement in line with the findings of this inspection such as the requirement to review documentation in the centre and the requirement for improvements to the maintenance and accessibility of both premises. Management and staff meetings were occurring regularly and the agenda items were found to be person-centred.

The staff team reported to the person in charge. Each of the staff who spoke with the inspectors were found to be knowledgeable in relation to residents' care and support needs. There were sufficient numbers of staff to meet residents' current care and support needs. The inspectors reviewed a number of staff files and found that two of those reviewed did not contain all the information required by the regulations. The provider sent assurances to the inspectors after the inspection that the required information was now in place in the two staff files.

Staff and volunteers had completed training and refreshers in line with residents' needs. A number of staff who spoke with the inspector were highly motivated and said they were supported and encouraged to carry out their roles and responsibilities to the best of their ability. Staff were in receipt of regular formal supervision.

The inspector reviewed a number of residents' contracts of care and they contained all the information required by the regulations including charges and additional charges which residents were responsible for in relation to their day-to-day care and support. They had been signed by the resident or their representatives.

Residents' were protected by appropriate insurance in place against injury to residents and other risks in the centre, including loss or damage to property.

There were a number of volunteers in the centre who were supporting residents in their home and to engage in activities of their choosing in line with their needs and wishes. The inspector spoke to residents and staff in relation to the positive impact for residents of spending time with their volunteers. The volunteers had access to the support, supervision and training. They had their roles and responsibilities in writing, and had completed Garda vetting prior to commencing in their role as a volunteer.

During the inspection, the inspectors found a number of restrictive practices which had not been notified to The Office of the Chief Inspector in line with the requirement of the regulations.

Regulation 15: Staffing

There were sufficient numbers of staff to meet residents' current care and support needs. Residents were observed to receive assistance in a kind, caring, respectful and safe manner throughout the inspection. The inspectors reviewed a number of staff files and found that two of those reviewed did not contain all the information

required by the regulations.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to training and refreshers in line with residents' needs. Staff were supported in their roles and were in receipt of regular formal supervision.

Judgment: Compliant

Regulation 22: Insurance

Residents were protected by appropriate insurance in place against personal injury and property damage.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures which identified the lines of authority and accountability for each staff member. The provider had completed the annual review of quality and safety of care in the centre and six monthly visits and the findings were similar to those of this inspection. However, they were not progressing the required actions identified in these reviews in a timely fashion.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Residents' admissions were in line with the statement of purpose. Each resident had a written contract of care which outlined the care, welfare and support to be provided, the services to be provided and the fees to be charged including additional fees if required.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all the information required by schedule 1 of the regulations and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Regulation 30: Volunteers

A number of volunteers in the centre were in receipt of regular support and supervision. They had clearly defined roles and responsibilities in writing and had completed Garda vetting. Residents and staff described the positive contribution they were making in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

During the inspection, the inspectors found a number of restrictive practices which had not been notified to The Office of the Chief Inspector in line with the requirement of the regulations.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the provider and person in charge were striving to ensure that the quality of the service provided for residents was good. Residents lived in a caring environment and residents who spoke with the inspector stated that they liked their home and were happy with the support they received from staff. They described opportunities for meaningful activities and told the inspector about things they had to look forward to. However, the premises was not fully meeting residents' needs in relation to accessibility and areas of the premises required maintenance and decoration. In line with findings of the providers own audits, improvement was required in relation to documentation in the centre to ensure it was fully guiding staff to support residents with their care and support

needs. In addition, the provider had recognised that there were compatibility issues between residents in one of the houses. There were safeguarding plans in place and the provider had plans in place to open another property.

Areas of the centre were found to be clean, warm, comfortable and homely including residents' bedrooms. However, in line with the findings of the last inspection the centre was not fully meeting residents' needs in relation to accessibility. A number of areas required painting and there were areas in need of repair such a hole in a door, damage to door frames, damage to floors in a number of areas, no door saddle between a number of doors and the exterior of one house required repair following works to the driveway. The inspectors acknowledge that a number of improvements had been made to the premises since the last inspection including additional fire containment measures, improvements to the driveway of one premises and painting and decoration in a number of areas.

Residents' had an assessment of need in place and a personal plan. These documents were found to be person-centred and residents had access to a keyworker to support them to develop and reach their goals. However, a number of assessments of need required review to ensure they were reflective of residents' needs and included a complete review of residents' health, personal and social care needs. There was duplication of documentation and some documents required review and update to ensure they were up to date and guiding staff to support residents fully with their care and support needs. Residents' preferred activities were highlighted in their personal plans as were the supports they required to engage in these activities. There was evidence of residents and their representatives input in the development and review of personal plans.

Residents were being supported to enjoy best possible health. They had access to allied health professionals in line with their assessed needs and staff were knowledgeable in relation to their care and support needs. They had support plans in place which were reflective of their current healthcare needs and clearly guiding staff to support them. Staff had access to training to support residents in line with their healthcare needs.

Staff had the up-to-date knowledge and skills to support residents to meet their assessed needs. Residents had support plans in place which were reviewed and updated regularly. However, there were a number of restrictive practices in the centre which had not been recognised as such. These included a key coded system on the front door of one premises and a locked gate in the back garden of another premises with a keycoded box containing the keys. They had not been risk assessed and as a result it was not evident that the least restrictive measure had been considered or implemented.

The inspectors found that the provider and person in charge were attempting to protect residents from abuse in the centre. They had appropriate policies and procedures in place and staff had access to training to support them to carry out their roles and responsibilities in relation to safeguarding residents. They had identified compatibility issues in the centre and had plans in place to register another premises to support one resident to transition from the centre. In the

interim they had safeguarding plans in place and there was evidence that staff were knowledgeable in relation to implementing them.

Residents were protected by appropriate procedures in relation to the ordering, receipt, storage and disposal of medicines. However, the policy in the centre required review as it was not reflective of practices described to the inspectors during the inspection. Staff and volunteers received training in the safe administration of medication training and practical administration prior to administering residents' medicines. Residents were being supported to take part in the administration of their medicines in line with risk assessment and capacity assessments. Medication audits were being completed regularly and medication incidents were recorded and fully investigated.

There was a residents' guide in place which clearly outlined the services and facilities provided for residents. It also detailed the terms and conditions relating to living in the centre, the arrangements for residents' involvement in the running of the centre, how to access any inspection reports, the procedure for complaints and the arrangements for visitors.

Residents were protected by appropriate risk management procedures and practices. However, the risk management policy in the centre did not contain all the information required by the regulations. It did not contain measures and actions in place to control; the unexpected absence of any resident, accidental injury to residents, visitors or staff, aggression and violence, and self-harm. There was a system for keeping residents safe while responding to emergencies. There was a risk register and risk assessments which was reviewed and updated regularly. Incident review and tracking was evident, as was the learning following incidents.

Regulation 17: Premises

Both premises were clean, warm, comfortable and homely. However, in line with the findings of the last inspection, the centre was not fully meeting residents' needs in relation to accessibility. In addition, areas of the centre required maintenance and decoration.

Judgment: Not compliant

Regulation 20: Information for residents

There was a residents' guide in place which contained all the information required by the regulations. The residents guide was available in the centre for residents and their representatives if they so wish.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by appropriate risk management procedures and practices. There were systems in place for responding to emergencies and arrangements were in place for identifying, recording, investigating and learning from serious incidents and adverse events. However, the policy did not contain all the information required by the regulations as outlined in the report.

Judgment: Not compliant

Regulation 28: Fire precautions

There were suitable arrangements in place to detect and extinguish fires and evidence of servicing of equipment in line with the requirements of the regulations.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Overall, residents were protected by policies, procedures and practices in relation to medicines management. However, the policy in the centre required review as it was not fully reflective of practices in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Overall, residents' personal plans were person-centred and they had access to the support of a keyworker to develop and meet their goals. However, some documentation including assessments of need and other documents in residents' personal plan required review to ensure they were consistent and reflective of residents' care and support needs.

Judgment: Substantially compliant

Regulation 6: Health care

Overall, residents were supported to enjoy best possible health. They had access to the support of relevant allied health professionals in line with their needs. Staff were knowledgeable in relation to their care and support needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had access to the support they required and there was evidence of regular review of their support plans and risk assessments. Staff had access to relevant training and refreshers to support residents. However, there were a number of restrictive practices in the centre which had not been recognised as such. Therefore, it was not evident that the least restrictive measures had been considered or implemented.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were protected by safeguarding polices, procedures and practices in the centre. Staff had completed training in relation to safeguarding residents and were knowledgeable in relation to their responsibilities. The provider had recognised that there were compatibility issues between residents in the centre. They had plans in place to register another premises in the centre and transition one resident into this premises. In the interim they were attempting to safeguard residents and had a safeguarding plan in place.

Judgment: Substantially 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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for L'Arche Ireland - Dublin OSV-0003418

Inspection ID: MON-0022528

Date of inspection: 19 and 20/06/2019

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: (1), (2), (3), and (4) have been read, understood and we are in a position to continue in compliance. (5) has been read, understood and we have now complied in respect of staff information and documentation specified in Schedule 2. The two staff files in particular that did not contain all of the necessary information have now been rectified.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: (1) (a) In to ensure the effective delivery of care and support we are researching all options to source funding for the project planned for L'Arche Dublin. This includes developing our capacity as an Approved Housing Body to have the required Governance in place, to source on going housing return and funding to do a major renovation on the three houses (Seolta, Leoithne and Baidin). Please see additional comments and actions listed under Regulation 17. Premises. (b) has been read, understood and we are in a position to continue in compliance. (c) has been read, understood and we are in a position to take further action in order to	

be in compliance by way of the comments list above in section (1) (a). Please see additional comments and actions listed under Regulation 17. Premises.

(d-f) has been read, understood and we are in a position to continue in compliance.

(2) (a) , and (b) has been read, understood and we are in a position to continue in compliance.

(3) (a) and (b) has been read, understood and we are in a position to continue in compliance.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
(1) (a), (b), (c), (d), (e), (f), (g) and (h) have been read, understood and we are in a position to continue in compliance.

(2) has been read, understood and we are in a position to act in compliance in the event of same.
(3) (a) has been read, understood and we are in a position to act in compliance in the event of same. A report shall be submitted, via the HIQA portal, starting for Q2 2019 and forward for each quarter, for each calendar year, on any occasion on which a restrictive restraint (physical, chemical, or environmental) was used. Risk assessment regarding same will be in place and the Management Team will conduct quarterly reviews on these and any other measures deemed necessary. These reviews will be carried out to ensure:

• Any restrictive measures used are applied in accordance with national policy and evidence-based practice
• Efforts are made to identify / alleviate the cause of the Resident's challenging behaviour
The least restrictive measures are in use and for the shortest duration necessary

(b –f) has been read, understood and we are in a position to continue in compliance.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

(1) (a), (b) and (c) has been read, understood and we are in a position to take further action in order to be in compliance. The focus of work on the houses will continue with the following measures:
• Corridor 2 (Seolta unit) to be painted by 30/09/2019
• Doors in Corridor to be repaired and painted by 30/09/2019
• Door saddles x 3 (Seolta unit) installed (completed on 05/07/2019)
• Fire Door (Seolta unit) repaired (completed on 05/07/2019)
• Exterior of Leoithne and Baidin units and wall to be painted by 30/10/2019

(2) has been read, understood and we are in a position to continue in compliance.

(3) has been read, understood and we are in a position to continue in compliance.

(4), (5) and (6) in order to move towards compliance L'Arche Dublin has engaged in the following actions:
I. L'Arche Dublin engaged with an inclusive communication team and a Architects, who specialise in working with people who have ID to explore what they require of their living space. in order to plan the future physical environment of the three units (Seolta, Leoithne and Baidin)
II. L'Arche Dublin commissioned a Feasibility Study for the development potential of the three houses by an Architect. This report details extensive (re) construction and extension of the entire centre. The capital expenditure for this project is between five and six million Euro. Funding and grant options are currently being investigated.
III. For example
IV. The Provider and PIC have meet with three different charitable foundations with the view to funding the current improvements and to research options for the major renovation required.
• The provider is researching all options to source major funding for the project planned for L'Arche Dublin. This includes developing the capacity as an Approved Housing Body to have the required Governance in place, to source on going housing return and funding to do a major renovation on the three houses (Seolta, Leoithne and Baidin).
(7) has been read, understood and we are in a position to continue in compliance.

In the meantime, renovations, works and decoration of the three houses will continue in a timely and on-going manner.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
(1), (a), (b), (c) (i) (ii) (iii) and (iv), (d), (e) has been read, understood and we are in a position to take further action in order to be in compliance.

(2) has been read, understood and we are in a position to take further action in order to be in compliance.

(3) has been read, understood and we are in a position to continue in compliance.

A new Risk Management Framework & Guidance policy document is currently in Draft format for the Dublin Community. It addresses comprehensively:

(a) hazard identification and assessment of risks throughout the designated centre;

(b) the measures and actions in place to control the risks identified;

(c) the measures and actions in place to control the following specified risks:

(i) the unexpected absence of any resident,

(ii) accidental injury to residents, visitors or staff,

(iii) aggression and violence, and

(iv) self-harm;

(d) arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving Residents; and

(e) 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. Although a significant portion of this framework is already in place, the measures and actions addressed in the new framework will be fully in place by 31/10/2019

A copy of the new Risk Management Framework & Guidance will be forwarded to the Regulator.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
(1), (2) and (3), have been read, understood and we are in a position to continue in compliance.

(4) (a), (b), (c) and (d) have been read, understood and we are in a position to continue in compliance.

(5) has been read, understood and we are in a position to continue in compliance.

It is acknowledged that in order for full compliance with all of the above and being cognizant of the recent report - our medication policy requires an overview to fully and more accurately reflect our practice in the centre. The Registered Provider, working with the PIC and the Nurse(s) will ensure that a new medication policy – one which is more reflective of practice in the centre, will be in place by 30/10/2019.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
5. (1) part (a) and (b), (2), (3) have been read, understood and we are in a position to be in compliance by the following action;

• A complete review of Resident's Health, Person and Social Care needs will be undertaken. This will in turn inform the individual Care Plans. This measure will be in place for all Residents by 30/10/2019

(4), (5) and (6) (a), (b), (c), and (d) has been read, understood and we are in a position to continue in compliance.

(7) (a), (b) and (c) and 8 has been read, understood and we are in a position to continue in compliance.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
7) (1), (2), (3) have been read, understood and we are in a position to continue in compliance.

(4) has been read, understood and we are in a position to continue in compliance.

(5) (a), (b) and (c) have been read, understood and we are in a position to take action to be in compliance. A report shall be submitted, via the HIQA portal, starting for Q2 2019

and forward for each quarter, for each calendar year, on any occasion on which a restrictive restraint (physical, chemical, or environmental) was used. Risk assessment regarding same will be in place and the Management Team will conduct quarterly reviews on these and any other measures deemed necessary. These reviews will be carried out to ensure:

• Any restrictive measures used are applied in accordance with national policy and evidence-based practice
• Efforts are made to identify / alleviate the cause of the Resident's challenging behaviour
• The least restrictive measures are in use and for the shortest duration necessary.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
(8) (1), (2), (3), (4), (5), (6), (7) and (8) have been read, understood and we are in a position to remain in compliance and take action to be in further compliance with the following measures:

• Residents will continue to be protected by clear safeguarding policies, procedures and practices in tandem with regular safeguarding refresher training for Residents
• Staff will continue with refresher training in low arousal intervention methods and safeguarding training
• New members of Staff will receive appropriate training, induction and supports to assist them in sustaining a safe environment for the Residents
Plans have been submitted to the regulatory to add an additional house to the current footprint in order to facilitate a safer and more therapeutic environment for the Residents by moving one Resident to help alleviate an identified compatibility issue between two Residents that has generated some safeguarding concerns

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(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	30/06/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/09/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/09/2019
Regulation 17(6)	The registered provider shall	Not Compliant	Orange	30/12/2019

	ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
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.	Substantially Compliant	Yellow	30/12/2019
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: the unexpected	Not Compliant	Orange	31/10/2019

	absence of any resident.			
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Not Compliant	Orange	31/10/2019
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Not Compliant	Orange	31/10/2019
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Not Compliant	Orange	31/10/2019
Regulation 29(4)(b)	The person in charge shall	Substantially Compliant	Yellow	31/10/2019

	ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health,	Substantially Compliant	Yellow	31/10/2019

	personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31/07/2019
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/08/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based	Substantially Compliant	Yellow	31/07/2019

	practice.			
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	31/07/2019
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	31/07/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/07/2019