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:	Sligo Semi Independent Accommodation
Name of provider:	RehabCare
Address of centre:	Sligo
Type of inspection:	Announced
Date of inspection:	29 May 2019
Centre ID:	OSV-0004442
Fieldwork ID:	MON-0022570

About the designated centre

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

Sligo Semi-independent accommodation provides residential support to male and female adults with an intellectual disability. The centre provides support to residents based on the social care model and provides low support to residents to assist them to maintain and develop independence in all aspects of daily living. Sligo semi-independent accommodation is located in a residential area on the outskirts of Sligo town, but close to local amenities such as shops and leisure facilities. The centre is also a short walk or accessible by public transport to further facilities and amenities in the town centre. The centre comprises of two houses in close proximity to each other. Residents have varied levels of independence and support needs. One house provides accommodation for three residents. Residents have access to a communal sitting room and kitchen/dining room as well as two bathrooms with shower facilities in each. The house also contains a staff office which caters for the administrative needs of both houses within the centre. The second house provides accommodation for four residents. Residents have access to a communal sitting room and kitchen/dining room along with a bathroom with a shower facility and an additional downstairs toilet. Both houses have rear gardens, which are accessible to residents at the centre. Residents are assisted by a staff team comprising of a team leader and community support workers. Staffing arrangements are provided at key times during the day to support residents with their assessed needs and to develop their independence skills. Support to residents on weekdays is provided by one staff member for set times in the morning and evening in line with individuals' assessed needs. Staff support is reduced at the weekend, with evening staffing arrangements in place on Saturdays, and no support provided on Sundays and on public holidays. In addition, no staff support is provided at the night-time

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
29 May 2019	15:30hrs to 20:00hrs	Thelma O'Neill	Lead
30 May 2019	10:30hrs to 17:00hrs	Thelma O'Neill	Lead
29 May 2019	15:30hrs to 20:00hrs	Mairead Murphy	Support
30 May 2019	10:30hrs to 17:00hrs	Mairead Murphy	Support

Views of people who use the service

Most of the residents living at the centre told inspectors they were happy and that they had good family support. In general, residents got on well with each other. However, there was some concern regarding compatibility and suitability of residents living with each other. Residents told inspectors that the staff were good to them, and they like the support staff. However, they said they would like more staff support to assist them to achieve their person centred goals.

Residents had completed a written questionnaire for the Health Information and Quality Authority (HIQA) on their opinions on the service they received, and most residents were satisfied with the care and support provided . However, one resident said they would like their meal times and social activities to occur during the day and to meet the person responsible for maintenance in their house, so they could get renovations done. They also raised concerns about their ability to evacuate from the upstairs of the house in the event of a fire.

Capacity and capability

This centre had a clearly defined management structure. However, inspectors found the operational management arrangements in place were poor, and improvements were required in the leadership and management arrangements to ensure effective oversight of the service.

The provider had appointed a person in charge to manage this centre. She was responsible for three designated centres in the locality, and had allocated her time to work one day a week in this centre. The person in charge demonstrated a good understanding of the residents' care and support needs, but the oversight arrangements had not ensured that residents' individual assessments and personal plans reflected their assessed needs. In addition, inspectors found that staff and the person in charge did not demonstrate an understanding of the provider's safeguarding policies and procedures, which had led to safeguarding concerns identified by inspectors not being reported to the chief inspector as required by the regulations. Furthermore, where residents had voiced complaints about the intimidating behaviour of a peer, their complaints were not identified as such, and therefore had not been recorded and subsequently investigated in line with the provider's policies and procedures.

The provider had ensured that there were systems in place to monitor and evaluate the quality of care provided to residents. Annual reviews and unannounced six monthly audits of the service were completed. However, inspectors found that

the provider's quality assurance systems had failed to identify or manage ongoing risks at the centre. For example, although risks associated with the changing needs of residents had been identified, inspectors found that a staffing support review had not been undertaken and effective measures were not in place to meet residents' needs. In addition, governance and management arrangements at the centre had not effectively addressed risks relating to safeguarding, the management of behaviours of concern, complaints, medication errors, gaps in fire evacuation procedures and staff training shortfalls.

Staffing arrangements in the centre were inadequate to meet the care and support and changing needs of the residents at the centre. For example; there was one staff available to support the residents in both houses in the morning and in the evening, but on Sundays, bank holidays and at night there was no staff support available to residents at the centre. Although residents were assessed as requiring minimum staff support, their care and support needs had changed, and staff acknowledged this to the inspectors, as there were several incidents in the centre where residents had not responded to fire alarms, or had issues with the cooker, and one resident had stayed out all night without staff knowledge and they were worried about their safety. Residents were told if they needed help outside staffed hours to seek support from the staff from another designated centre, and this had happened on several occasions recently, but there was no assurance this support would be available to residents when needed. Inspectors also found that the lack of staff support had impacted on the residents health and social care goals and there was not robust cleaning arrangements in place to support residents in maintaining their personal space. In addition, residents expressed to inspectors that they would like more staff to support them in the centre and with their social activities.

On the day of the inspection, inspectors found the staff roster did not accurately reflect the planned and actual staff on duty in the centre and it was not clear of the staffing arrangements in the centre. The person in charge agreed to change the staff roster to reflect the actual staff working in this centre.

Staff training was not up-to-date and staff required refresher training in fire safety, safe moving and handling, epilepsy training and infection control. In addition, the inspectors found on review that staff training was actioned on the last inspection and was not complete.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre; however, inspectors reviewed the documentation received and found that the floor plans, residents' guide and statement of purpose all required additional information to ensure compliance with the requirements of the regulations.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was responsible for management of three designated centres. However, the person in charge's oversight arrangements at this centre did not ensure its effective governance and management and compliance with the regulations.

Judgment: Not compliant

Regulation 15: Staffing

There was not adequate staff support provided in this centre to meet the changing care and support needs of the residents, or the size and layout of the designated centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff working in the centre did not have up to date training in fire safety, safe moving and handling, epilepsy management, and infection control. This was an action from the last inspection not addressed.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not ensured that the centre was adequately resourced to effectively meet residents' assessed needs. Furthermore, the provider's quality assurance systems had not effectively identified or put plans in place to manage risks at the centre, which had been an action highlighted in the previous inspection report.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose submitted to HIQA as part of the registration renewal documentation did not record the current governance structure at the centre and required review. It also did not reflect the actual staff support need requirements in the centre to meet the residents' current care and support needs.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Residents complaints to staff about safeguarding issues were not identified, recorded or investigated by the provider as a complaint. Furthermore, inspectors found during the inspection that staff at the centre did not demonstrate a good understanding of the provider's complaints management policy and procedures.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had not ensured that schedule 5 policies required under the regulations were regularly reviewed every three years to ensure they were up-to-date, which had also been previously identified as an action at the last inspection. The provider for example had not ensured that their staff training and development policy, medication management policy, and management of personal records policy were reviewed in line with the regulations' requirements.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not notified the chief inspector of safeguarding concerns which had occurred at the centre in line with the requirements of the regulations.

Judgment: Not compliant

Quality and safety

Inspectors found that the quality and safety of care in this centre did not effectively meet the assessed needs of the residents. While residents told inspectors that they were generally happy living at the centre, some residents told inspectors they would like more staff support for safety reasons and to enable them to have more meaningful and active lives.

Residents' individual assessments and support needs did not reflect their assessed care and support needs. For example, although the person in charge was aware that residents' needs were changing due to their age, with some residents requiring more support and supervision to meet their health and social care needs, additional staff support had not been put in place or residents' needs assessments did not reflect their current or future needs. In addition, the provider had not ensured that appropriate supports were put in place to meet identified risks such as a resident's excessive alcohol consumption, safeguarding risks relating to another resident staying overnight away from the centre with out staff knowledge, food safety and cooking risks, and the assessment of residents' compatibility at the centre due to recorded behaviours of concern; which were also not recognised by staff as safeguarding concerns in nature.

Residents living in the two houses in this centre did not feel safe due to a peer frequently displaying intimidation towards them, their staff, and their environment. The staff did not identified the incidents as safeguarding risks, despite residents raising complaints to the staff team on a regular basis, and the residents did not have a safeguarding plans in place to protect them. In addition, the resident that was displaying behaviours of concern towards their peers and staff working in the centre did not have a review with the positive behaviour specialist since April 2018, despite their behaviour negatively impacting on the individual themselves, their peers, and staff. These regulations were actioned on the last inspection and was not appropriately addressed.

While the provider had implemented risk management procedures to assess risks and respond to adverse incidents at the centre, staff were not responding to identified risks in line with the provider's risk policy. For example, the centre's risk register did not reflect all the risks in the centre, and the person in charge had not escalated ongoing risks to the senior management team; such as, staffing allocation, behaviours of concern, medication risks, safeguarding risk and fire safety risks. Inspectors noted that in most of the organisational and individual risks assessments reviewed, the risk measures in place to control the risks were external supports from another designated centre, but there were no assurance or systems in place to ensure that the support would be available as and when required.

Inspectors found that fire safety arrangements at the centre were not robust in nature. The provider did not ensure that fire safety checks were appropriately maintained at the centre, and staff fire safety training was not up-to-date.

Furthermore, residents who were frequently unsupervised by staff at the centre were not familiar with the centre's fire evacuation procedure and where to go to in the event of a fire. Inspectors further noted that the centre's fire evacuation plan was not up-to-date and reflective of the actual fire evacuation procedure in place on the day of inspection. In addition, residents' personal emergency evacuation plans (PEEPS) did not reflect their medical conditions, or their required support needs in the event of evacuation from upstairs of the houses.

Residents at the centre were assessed as being able to self administer their own medication. However, inspectors found that although residents were initially assessed as being capable of self medicating, there had been frequent medication errors recorded by staff where residents had not taken medication as prescribed. Inspectors noted that although this risk had been identified at the centre, no up-to-date assessment had been completed to ensure that residents had the necessary supports and skills to continue to self administer their medication and reduce the risks of further medication errors from occurring.

Regulation 26: Risk management procedures

The management of organisational and individual risks in the centre was not effective in nature especially for example in relation to the management of safeguarding risks, alcohol consumption, fire safety and medication errors. Furthermore, the centre's risk register did not identify all of the risks at the centre, and where required had not been escalated by the person in charge in line with the provider's risk management policy .

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety management was not robust and required review, for example, in fire precaution measures, staff training, evacuation procedures.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found there was poor medication administration practices in the centre and the management of medication errors were not in line with the organisation's medication management policy and procedures.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents personal plans did not reflect their changing care and support needs and the suitability of residents living together had not been reviewed despite safeguarding concerns in the centre. This was an actioned on the last inspection and not addressed.

Judgment: Not compliant

Regulation 6: Health care

Residents told the inspector that their health care needs were being met and inspectors reviewed evidence to show they had regular reviews with their general practitioner as required

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff did not respond to behaviour that is challenging in line with the organisation's policies and procedures.

Judgment: Not compliant

Regulation 8: Protection

Residents did not feel safe in the centre due to fear of intimidation and aggression from their peer. Residents were not appropriately supported to develop the knowledge and self awareness and skills needed for self-care and protection.

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	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Sligo Semi Independent Accommodation OSV-0004442

Inspection ID: MON-0022570

Date of inspection: 30/05/2019

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: • Floor plans, the Residents' Guide and the Statement of Purpose as per requirements have been amended and re-submitted to HIQA.	
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: RehabCare ensures that all PICs are suitably qualified and have the required experience required before appointing PICs to manage designated centres. PICs are supported by PPIMs to fulfil their duties. • A review of the allocation of hours of PIC to each designated site will be conducted by the 31/07/19 by the Integrated Services Manager and PIC to ensure adequate oversight arrangements and effective governance and management of sites. • A full review of staffing, informed by the changing care and support needs of the Service Users, will be led by the Integrated Services Manager and completed by the 31/07/2019. Following this review should additional resources be required a business case will be submitted to the HSE. • The Person in Charge's auditing tool has been amended and weekly management	

checks of daily logs and incidents have been introduced. These checks have commenced from 1/07/19 and will be completed weekly by the PIC ongoing.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• A full review of staffing, informed by the changing care and support needs of the Service Users, will be led by the Integrated Services Manager and completed by the 31/07/2019. Following this review should additional resources be required a business case will be submitted to the HSE.
• A new reconfigured model of staffing will be developed for the service appropriate to the number and assessed needs of residents, statement of purpose and the size and layout of the service. This will be contingent on current funding and will be completed by 31/07/19.
• A review of the roster will be completed to ensure appropriate staffing levels are in place. This will be completed by 31/07/19. PIC will ensure planned and actual up to date rotas are in place in the services at all times.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• Fire safety training for one staff member was completed on the 14/06/19.
• Manual Handling training for one staff member was completed on the 06/06/19.
• Four staff have attended refresher training in Safeguarding on 24/06/2019, two remaining requiring refresher training will complete on an online module by 31/07/2019 and will attend a training session on 04/09/2019.
• All staff completed training on the Regulations on the 2/07/19.
• All staff completed Report Writing Training on the 2/07/19.
• One staff member scheduled to attend Epilepsy Management training on the 19/07/19.
• All staff will have completed on line training on infection control on line by the 31/07/2019.
• All staff will complete Complaints Management training by 31/07/19
• PIC will review staff training quarterly at supervision to ensure all staff have up to date appropriate training.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• A full review of staffing, informed by the changing care and support needs of the Service Users, will be led by the Integrated Services Manager and completed by the 31/07/2019. Following this review should additional resources be required a business case will be submitted to the HSE.

• The Person in Charge's auditing tool has been amended, weekly management checks of daily logs and incidents have been introduced. These checks have commenced from 1/07/19 and will be completed weekly by the PIC ongoing.
In addition, staff have been instructed to immediately escalate any safeguarding concerns and/or potential complaints to management.

• The PIC and Integrated Services Manager (PPIM) will review the progress of the centre against the compliance plan on a fortnightly basis. This will be completed ongoing from week commencing 8.7.19 for a 6 month period to 31.12.19.

• The completion of actions identified in this compliance plan will be tracked on the organisation's action tracking database, progress on completion of actions will be reported on a monthly basis to the organisation's Senior Leadership Team and Board. This report will continue until all actions have been completed.

• A member of the organisation's Quality and Governance Directorate completed a review of the service on the 13/06/2019 and 14/06/2019, an action plan was generated from this review, actions from this review have been included in this compliance plan.

• The organisation's is currently reviewing its six monthly internal audit process. This review will include a review of the tool in use and the resources required to meet this requirement. A new tool is currently being trialed on a pilot basis. It is expected that the new tool will be rolled out for use across the organisation by 30/09/2019.

• A schedule of consistent and effective staff supervision will be implemented in line with Rehab Group Supervision Policy. The effectiveness of supervision practices will be reviewed at monthly progress meetings between the ISM and PIC. This will be ongoing from July 2019

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been revised and re-submitted.
• A full review of staffing, informed by the changing care and support needs of the Service Users, will be led by the Integrated Services Manager, by the 31/07/2019, following this review should additional resources be required a business case will be submitted to the HSE.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• A retrospective review of daily logs has been completed and concerns identified have been recorded as complaints and dealt with accordingly.
• Going forward all complaints will be recorded on the organisation's complaint management database.
• Staff Team have been advised of their responsibilities to recognize, record and report all complaints made by residents.
• The PIC will monitor all documentation in the service including daily logs and keyworker reports to ensure all complaints are identified and managed appropriately.
• All staff are scheduled to attend training on the organisation's complaints procedure before the end of 31/07/2019.
• The PIC will conduct an audit of Complaints on a monthly basis to ensure all complaints are being appropriately responded to and records of all complaints is maintained appropriately in the service.
• The management of complaints will be reviewed monthly at progress meetings between the PIC and ISM. This will be completed ongoing from week commencing 8.7.19 for a 6 month period to 31.12.19. Complaints management will also form part of Supervision meetings at least every quarter.
• All complaints will be escalated in accordance with RehabGroup Complaints Policy.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The Staff Learning & Development Policy has now been reviewed and is available in the service.
The Medication Management Policy review has been deferred to the end of August 2019.

This was due for a 2-year review in March 2019 but has been deferred to accommodate feedback from work being done by the lead author with the HSE on developing guidance for medication management in community settings.

• A local statement on how service users can access their files will be developed, all residents will be informed of same by 31/07/2019.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• A retrospective review of daily logs was completed on the 13/06/2019 and retrospective notifications and Preliminary Screenings were completed.

• A number of staff have attended refresher training in Safeguarding on 24/06/2019, two remaining requiring refresher training will complete on an online module by 31/07/2019 and will attend a training session on 04/09/2019.

• All permanent staff attended training on the Regulations on the 2/07/19.

• Staff have been instructed to immediately escalate any potential safeguarding concerns and/or complaints to management.

• The Person in Charge's auditing tool has been amended and weekly management checks of daily logs and incidents have been introduced. These checks have commenced from 1/07/19 and will be completed weekly by the PIC ongoing.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The risk register will be updated by the 12/07/19 by the PIC to ensure it records all risks at the centre.

• A Service User's self-medication assessment, medication management plan and risk assessment were reviewed on the 15/06/19. This service user is no longer self-medicating. This will be reviewed again by 30/09/19.

• A Service User's risk assessment regarding use of the cooker was reviewed on the 15/06/19 and this resident is no longer using the cooker without staff supervision. A further skills development course is being implemented and the assessment will be reviewed by 30/09/19 following programme completion.

• Night time fire drills were completed on the 18/06/19. On this occasion all resident's present evacuated within the required timeframes. A night time drill will be completed twice annually going forward.

• The alcohol consumption risk assessment will be reviewed by the 12/07/19 and additional supports will be offered to the Service User concerned.

• The PIC will review this Compliance Plan with the Integrated Services Manager every two weeks until all actions have been completed. Specific areas of concern will then be escalated according to policy and discussed with the PPIM at fortnightly meetings.

• Risk management will be a standing agenda staff team meetings from July 2019 onwards.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Staff training was completed on the 14/06/19.
• Night time fire drills were conducted again on the 18/06/19. On this occasion all resident's present evacuated within the required timeframes. Night time drills will be completed twice annually going forward.
• Fire evacuation procedures and particular concerns raised by a Service User have been discussed and reviewed through key working sessions. This has been recorded in key working notes.
• Fire evacuation procedures have been made a standard agenda item for house meetings and will be discussed with all Service Users individually by 31/07/2019.
• The evacuation plans on display have been amended to accurately reflect the service.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• A Service User's self-medication assessment, management plan and risk assessment were reviewed on the 15/06/19, this resident is no longer self-medicating. This will be reviewed again by 30/09/19. • There is plan in place to support the resident and raise awareness around medication routine with a view to supporting the resident returning to self-administration of their own medication in line with their wishes.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The compatibility Risk Assessment will be reviewed by 15/07/2019. Additional control measures that have been put in place will be reflected.
• The Service User was referred to the HSE Psychologist on the 31/05/19. Due to the 6-month waiting list the service user has now been referred to a private psychology service. It is expected that an initial meeting will take place by 2.9.19.
• The Behavioural Therapist met with staff on the 18/06/19 to discuss the current situation. The behaviour support plan is currently being reviewed.
• Staff are providing more structured 1:1 with the Service User every week, there are four one hour sessions facilitated each week. These hours are clearly identified on the rota. The purpose of these sessions is to promote positive behaviours and in doing so address safeguarding concerns in the service.
• The resident will be consulted in respect of their choice of future living arrangements, plans to facilitate same will be developed if required.
• A retrospective notification and preliminary screening has been completed for other Service Users living in the house.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The Behaviour Therapist commenced a review of one of the Service user's Behaviour Support Plan on 18/06/19.
• A Service User was referred to the HSE Psychologist on the 31/05/19. Due to the 6-month waiting list the service user has now been referred to a private psychology service. It is expected that an initial meeting will take place by 2.9.19
• Staff have been reminded of their responsibility to record all incidents of negative peer

on peer interactions and to escalate these to the PIC. The PIC will monitor all incidents with a view to ensuring that plans in place are effective, where required in consultation with members of the MDT adaptations will be made to the plan.
• A retrospective review of daily logs was completed on the 13/06/19 and retrospective notifications and preliminary screenings were completed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A safeguarding awareness programme is being implemented with Service Users. This will be completed by 31/08/19.
• The organisation's Complaints Officer will deliver complaints training for staff and a complaints awareness session to Service Users by 31/07/19.
• A Safeguarding plan has been completed for four resident's which acknowledges the impact of another resident's behavior on them and identifies supports being offered to them.
• The advocacy officer will offer each resident the opportunity to avail and meet with an independent advocate external to Rehab. If residents wish to avail of this support, a referral will be made to the relevant organization. This will be completed by 31.7.19.
• The Safeguarding Plans will be regularly reviewed to ensure measures identified are effective, the PICs review of incidents and daily logs will inform this process.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	30/06/2019
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	31/07/2019

Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/07/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	04/09/2019
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	31/07/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate	Not Compliant	Orange	30/09/2019

	to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant		31/07/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/07/2019
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant		31/07/2019
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive	Not Compliant	Orange	14/06/2019

	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.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/07/2019
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	Orange	14/06/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of	Not Compliant	Orange	15/06/2019

	capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/07/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	30/06/2019
Regulation 34(1)(b)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall make each resident and	Not Compliant	Orange	31/07/2019

	their family aware of the complaints procedure as soon as is practicable after admission.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/08/2019
Regulation 05(6)(b)	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 be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant		15/07/2019
Regulation 07(3)	The registered provider shall	Not Compliant	Orange	31/07/2019

	ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	31/08/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/06/2019
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	04/09/2019