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

Issued by the Chief Inspector

Name of designated centre:	Heather Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Roscommon
Type of inspection:	Unannounced
Date of inspection:	07 January 2020
Centre ID:	OSV-0004461
Fieldwork ID:	MON-0028057

About the designated centre

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

Heather services, is a residential service located on the outskirts of a busy town in Co Roscommon. Heather Services provides accommodation and support for up to seven adults with intellectual disabilities in two separate bungalows in residential areas. The larger building accommodates six residents and is divided into two residential units which are interconnected. One resident lives in the second bungalow. All residents have their own bedrooms with some having ensuites. In both houses there are also adequate communal rooms for people to have visitors and privacy. The service supports residents with high support needs. Residents are supported with a staffing skills mix of senior staff nurses, staff nurses, social care workers, community facilitator and community connectors. Waking night duty and sleepover staff are in place. People avail of day services from their home. Transport is provided to access work, education/training and leisure facilities in the community. Residents are supported to be active participating members of their local communities. They use the local amenities including – restaurants, public houses, hotels, shops, parks, cinemas, arts centres, libraries, church, bowling alley, and swimming pools.

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
07 January 2020	09:30hrs to 18:30hrs	Noelene Dowling	Lead
07 January 2020	09:30hrs to 18:30hrs	Sarah Barry	Support

What residents told us and what inspectors observed

Inspectors met with four of the residents who lived in the larger of the two houses which made up the centre. Inspectors did not visit the second smaller house on this inspection.

The residents could not verbally communicate with the inspectors but did allow inspectors to observe some of their routines and activities. They were having breakfast and getting ready to go for an outing when inspectors arrived and returned later in the day for their lunch. They appeared comfortable in their home and staff responded to and were familiar with their non- verbal communication. The residents appeared well and their primary care needs were being well supported by staff that were attentive to them. They supported them sensitively with their meals and their tasks.

The premises had been newly painted and the residents bedrooms were personalised .

Capacity and capability

This inspection was carried out in order to follow up and verify the provider actions in relation to the compliance plan submitted to the Chief Inspector following a risk based inspection in October 2019. Due to the nature of the non-compliances found on that inspection, the provider was required to attend a formal meeting with HIQA and was issued with a warning letter advising that they were required to address the issues by the 12 December 2019. The provider was required to provide assurances to the Chief Inspector as to how these non-compliances were to be addressed.

This inspection found that progress had been made in some areas of the centre to improve the service delivered to residents and to better resource the centre. However, further improvement was still necessary in some key areas including effective governance and staffing arrangements, where actions had not been fully implemented in line with the timescales outlined in the provider's compliance plan.

Since the last inspection a new dedicated person in charge had been appointed to the centre. This person had the appropriate qualifications and experience to carry out the role and was now working in the centre on a full time basis. However, the agreed protected time had not yet been made available, to ensure the person in charge could effectively provide the direction and oversight necessary in the centre. The inspector was advised that ten hours protected time was available to the person in charge, from the date of this inspection,to ensure this oversight was

available.

As part of the compliance plan from the last inspection, the provider stated that staffing arrangements in the centre had been revised and augmented, following a review. Inspectors found that some improvements had been made and the provider was in the final stages of recruiting four new staff for the centre. This would allow the person in charge to have more supernumerary hours and have better oversight of the centre. Inspectors were advised that the increased staffing would be in place by 21 January 2020. At the time of this inspection, some issues with the staffing arrangements had not yet been addressed and were overdue as per the provider's action plan response. For example, the provider said that there would be provision on the roster for a staff member to be available as a floating staff to cover both houses which made up the centre and facilitate a residents individual activities, but this had not yet been put in place. Additionally, the provider's revised staffing arrangements had resulted in a period in the mornings and afternoons where there was only one staff member on duty in the larger house. Staff advised that this had been problematic, when, for instance, the residents required additional attention or personal care, and this arrangement required further review. Inspectors were informed that these issues would be addressed through the recruitment of the additional staff.

From a review of the staff training records, it was apparent that the required mandatory training was being provided and scheduled for staff. This included both mandatory and additional training pertinent to the resident including dysphasia and falls prevention. However, there were gaps in staff attendance at this mandatory training which had not been addressed adequately. This included safeguarding, management of behaviours that challenged and administration of emergency medicines.

While it was evident that systems were in place to respond to any adverse event that occurred in the centre, further improvement was required. For instance, from a review of a number of adverse events, the inspector found that there was a lack of adequate reviews of such incidents by management to ascertain the causes and prevent re-occurrences. The provider was not adequately analysing the data collated on these incidents in a way that would allow them to change practices where necessary.

There had been an improvement in adherence to the requirement to submit the required notifications to the Chief Inspector but a specific restrictive practice implemented was not submitted.

Having reviewed the complaints records, inspectors found that complaints made on behalf of the residents were being addressed in a prompt and reasonable manner. Other matters had been addressed including painting and decorating of the premises.

It is acknowledged that the revised management structure was only being implemented at the time of the inspection. These factors can account for some of the findings of this inspection. Plans, including increased resources, changes to the

deployment of staff and better oversight were outlined to the inspectors which were aimed at further addressing the non-compliances identified.

Four of the seven non-compliances from the last inspection had not been satisfactorily addressed. While some progress had been made, and the specific non-compliance in relation to restrictive practices and residents' rights were addressed satisfactorily, further improvements were required in these areas. The findings from the inspection were discussed and communicated directly to the residential services manager and the person in charge at the close of the inspection.

Regulation 14: Persons in charge

A dedicated person in charge had been appointed to the centre who had the required experience and qualifications. However, the necessary protected time had not been made available so as to ensure that the function could be carried out effectively.

Judgment: Substantially compliant

Regulation 15: Staffing

While additional staff were being recruited for the centre staffing arrangements remained unsatisfactory at the time of this inspection.

Personnel files reviewed indicated that recruitment procedures were satisfactory.

Judgment: Not compliant

Regulation 16: Training and staff development

The required mandatory training was been provided for staff and this included both mandatory and additional training pertinent to the residents including dysphasia and falls prevention. However, there were gaps in attendance by staff at the mandatory training which had not been addressed by management. This included safeguarding, management of behaviours that challenged and administration of emergency medicines.

Judgment: Substantially compliant

Regulation 23: Governance and management

It was evident that improved oversight structures were being implemented and a new dedicated person in charge had been appointed to the centre. However, at the time of inspection the person in charge did not have sufficient protected time to over see the centre. As a result it was not evident that a sustainable system of governance and management was in place. This was also evident in the systems for reviewing incidents that occurred in the centre, systems for ensuring that staff attended the mandatory training provided and continued non-compliance as observed in the quality and safety section of this report.

Judgment: Not compliant

Regulation 31: Notification of incidents

While there had been an improvement in adherence to the requirement to submit the required notifications to the Chief Inspector, a restrictive practice used had not been submitted as required.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Having reviewed the complaints records, inspectors found that complaints made on behalf of the residents were being addressed in a prompt and reasonable manner.

Judgment: Compliant

Quality and safety

Improvements were still required in systems to promote the quality of life and safety

of the residents based on their complex need. The residents’ primary and healthcare needs continued to be very well supported, with prompt and frequent access to all necessary multidisciplinary assessments and reviews including general healthcare, neurology, speech and language, physiotherapy and mental health specialists. Suitable support plans were devised and seen to be implemented. These factors and the presence of nursing staff promoted the residents health and wellbeing, which was seen to be carefully monitored.

Despite this good practice, systems for assessment of the residents' overall social care needs including specific therapeutic interventions, and day-to-day routines for the residents required review by management.

The issues from the previous inspection in regard to the residents' access to meaningful and person-centred activities remained unsatisfactory, with no substantive changes made to address this. One of the houses which comprise the designated centre was effectively divided into two sections and staffed separately. There was a distinct difference between these two sections of the centre in the residents’ access to the community, meaningful activities, recreation and day-to-day routines. This difference cannot be accounted for by differences in the resident’s needs or abilities. The residents did not attend day services and inspectors were advised that service operated a wrap round day-service from the centre. However, the rational for providing day service activities was not based on assessment or consultation with residents.

As part of the provider’s response to the compliance plan, training for the staff in the implementation of meaningful person-centred activities or routines for the residents had taken place. This had not resulted in changes to routines or any therapeutic interventions which may enhance the quality of the residents’ day-to-day life, however.

As a result residents went on frequent drives but it was not evident that this was based on consultation or preference. One resident particularly liked swimming but had not been able to access this since July 2019. It was apparent that there was no oversight or review of the residents’ activities or goals, or their continued suitability for the residents. The provider outlined plans to address residents' social care needs, based on restructuring of the centre and changes to rosters, which they envisage will address some of these matters with staff changes to take place by 21 January.

The systems for safeguarding of residents required some improvements. The provider was seen to act appropriately and promptly to address any instance where the residents were subjected to any inappropriate or harmful action. There was evidence of reporting to the relevant agencies and investigations being carried out. The provider has an integral social work service which oversaw this.

However, there were other safeguarding matters noted in this inspection. A significant amount of residents’ funds had been used to purchase a vehicle. The provider had informed HIQA that there was a signed agreement in place with appropriate representatives of the residents to allow for this. However, inspectors

were provided with this document and found that this agreement was only signed on behalf of one resident.

In addition to this, the provider was acting as de-facto guardian for a resident which was an arrangement that had evolved over time. The inspectors were informed that there was no framework or arrangement in place internally, by which the resident's rights was being protected in this instance. This included how, or who, made decisions regarding the management of care, treatment, and financial decisions for the resident. This matter needed to be reviewed and addressed in full.

All of the residents required full support with their finances. While there were detailed records of withdrawals and expenditure maintained in the centre, inspectors saw that there was no management oversight of this undertaken in 2019. While there was no evidence, or suggestion, of any untoward actions in relation to the above matters, the lack of formal arrangements and oversight creates a vulnerability and risk for the residents.

The residents required full support with personal care. The plans available did not provide any guidelines as to how to protect the residents' privacy, dignity and integrity in this matter. One of the main bathrooms was also the en suite for a resident's bedroom. Staff informed the inspector that on occasions, another resident enters the bathroom when residents are having personal care attended to. The door is not locked and arrangements were not adequate to protect the resident's privacy,

There were however, good access to supports for the management of behaviours that challenged with detailed behaviour support plans implemented. These behaviours were not a significant feature of this service. The provider had initiated a procedure to ensure that a restrictive practice noted at the previous inspection was no longer implemented.

Nonetheless, the procedures for decision making and oversight of the restrictions in the centre were not robust. A number were historical practices. For instance, for safety reasons, a resident had limited access to the kitchen. However, the room mainly used by the resident contained a large window which gave a direct view into the kitchen. Inspectors saw that this was a source of increased anxiety, when meals were being prepared, given that the resident wished to access the kitchen, but could not do so. Inadequate consideration had been given to this impact of this arrangement on the resident.

A number of incidents reports seen by inspectors detailed that a resident was "removed to a chair" in response to behaviours that challenged. There was no evident review of these incidents so as to ascertain precisely what took place or how it was done. This constituted a potential risk which required review from a risk management perspective as well as a restrictive practice perspective.

The policy on such procedures stated that all restrictions are reviewed by the provider's rights committee to ensure they remain necessary, are the least restrictive, are in accordance with the national policy. However, inspectors were informed that this committee was not currently operating.

Overall, the residents were protected by the systems in place for risk management and there were detailed individual risk management strategies implemented for pertinent issues such as falls, seizure activity. These were reviewed frequently and additional assessment and supports sourced as needed.

There were systems in place to ensure the prevention of fire, and the safe management of any such emergency including systems for detecting, containing and extinguishing fires. None the less, while fire drills were taking place in the centre, the provider had not conducted a fire drill to reflect the reduced staffing levels at night. In addition to this, the fire evacuation plan detailed the use of volunteers to assist the staff. Some key staff were not aware of this arrangement which was of concern. Inspectors also observed that exit doors were locked via unsecured keys. This would present a risk should these keys not be available during an emergency and this system required review.

Medicine management practices were reviewed and in the most part safe. However, the inspector found that the protocol for an emergency medicine was unclear and the prescription and dosage available did not match the protocol. Regular medicines audits took place which was evidence of good practice on the part of the provider.

Regulation 26: Risk management procedures

The residents were protected by the systems in place for risk management and there were detailed individual risk management strategies implemented for pertinent issues such as falls or seizure activity.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place to ensure the prevention of fire, and the safe management of any such emergency including systems for detecting, containing and extinguishing fires.

Nonetheless, while fire drills were taking place in the centre, the provider had not conducted a fire drill to reflect the reduced staffing levels at night.The fire evacuation plan detailed the use of volunteers which was an arrangement which some key staff were not aware of. The fire evacuation plan required full review.

Exit doors were locked via unsecured keys. This would present a risk should these

keys not be available during an emergency.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medicine management practices were reviewed and in the most part safe. However, the inspector found that the protocol for an emergency medicine was unclear and the prescription and dosage available did not match the protocol.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The residents' primary care needs were well supported and monitored with prompt and frequent access to all necessary multidisciplinary assessments and reviews including neurology, speech and language, physiotherapy and mental health specialists. Suitable support plans were devised and seen to be implemented.

However, some residents' social and therapeutic care needs had not been adequately assessed or identified and this resulted in lack of access to meaningful activities, recreation and day-to-day routines based on their abilities and preferences.These social care needs were not consistently addressed for all resident at residents' annual reviews.

Judgment: Not compliant

Regulation 6: Health care

Residents healthcare was well monitored and any changes responded to promptly.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was good access to clinical supports for behaviours that challenged.

The provider had addressed the inappropriate use of a restrictive practice identified at the previous inspection.

However, the impact of some restrictions on the residents quality of life was not considered via assessment or review.

In addition, from a review of a number of incidents of challenging behaviours, there was no evidence that these had been adequately reviewed to ascertain if the actions taken, including the use of restrictions, were in fact safe and appropriate.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were not protected by the current systems in place for the oversight and management of financial and care decisions.

Intimate plans did not demonstrate that the residents' needs for privacy and dignity were protected in providing this support.

The arrangements whereby the provider was making decisions on behalf of residents required full review.

Judgment: Not compliant

Regulation 9: Residents' rights

The residents privacy was impacted on by the failure to ensure that their personal care was carried out in private.

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 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Heather Services OSV-0004461

Inspection ID: MON-0028057

Date of inspection: 07/01/2020

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The person in charge is now working 12 hours protected management time, and is facilitated to do this through the revised roster. The PIC has additional support from the Residential services manager which is focusing initially on planning and systems.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The recruitment process has been successful and four new staff have been inducted and have commenced in all houses. There is a minimum of two staff on duty at all times. Rosters have been reviewed to ensure there is adequate support for all attention or personal support required.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All mandatory training needs have been identified and addressed. PIC has followed up	

with all staff in relation to planning for their training.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The person in charge is now working 12 hours protected management time, and is facilitated to do this through the revised roster. The PIC has additional support from the Residential services manager which is focusing initially on planning and systems.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Outstanding notification relating to privacy and dignity has been submitted and under ongoing review.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Individual Emergency Evacuation Plans have been reviewed and updated. All staff are aware of these updates and this is on the team meeting agenda. The contacting of neighbours in an emergency has been clarified for all staff members. Night time fire drill has been completed with minimum staffing levels. There is a new protocol on the management of keys.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The emergency medication management has been reviewed. The protocol is written up clearly with the prescription and dosage matching the protocol.	
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 PIC works as part of the rostered frontline support staff. The PIC is ensuring that meaningful activities are carried out by staff in line with people's interests using the Personal Outcomes Measures Planning tool. The person in charge is auditing and monitoring the quality of this planning on a monthly basis. There are continuing workshops in place to support the Personal Outcome Measures Planning processes to support the development of people's meaningful goals and interests. The next one will take place on 27th of February for the staff team and PIC with the Quality Enhancement department. A creative teams workshop is also being planned to support the team with any challenges in implementing these goals and plans and this process commences on 28th February. The Personal Outcome Measures assess the needs of each person and the areas of priorities in their lives. Through this process the assessed needs of each person is being reviewed and updated. This includes regular MDT input and this input is available as required by each person. Through this process of assessment, the priority goals and the assessed needs of each person is recorded and monitored.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The PIC is auditing and monitoring all behavior support plans and incidents to ensure that all restrictions associated with people supported are under regular review and the least restrictive environment possible is continually aimed for. There is also a review of the layout of the house which involves reconfiguration of the use of some of the rooms which will reduce the impact of recommended and upheld restrictions on each person supported.	

This review of the layout of the house is also working towards reducing restrictions.
The team continues to be supported by the Behaviour Support team who review and respond to any areas of concern for each person supported.

The Human Rights Review Committee has met as of the 29th January 2020.

The Annual Review template has been amended to reflect the MDT input in the service.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All documentation relating to the purchase of the house vehicle is now present and accessible on each file.

A process to achieve Ward of Court status for two people supported has begun to ensure there are arrangements in place for making decisions on behalf of the people supported.

All intimate care plans for people supported are being reviewed. Review of Intimate Care plans is on the agenda for team meetings. A protocol around privacy has been circulated to all staff. This is also on the agenda of team meetings to ensure there is ongoing review of privacy and support for intimate care.
Staff team will also be supported by a Personal Development, Relationships and Staying Safe Training which will further train staff on support for Intimate and Personal Care Plans. This training will commence on 18th March.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All intimate care plans for people supported are being reviewed. Review of Intimate Care plans is on the agenda for team meetings. A protocol on privacy has been circulated and discussed with all staff. This is also on the agenda of team meetings to ensure there is ongoing review of privacy and support for intimate care.
Staff team will also be supported by a Personal Development, Relationships and Staying Safe Training which will further train staff on support for Intimate and Personal Care Plans. This training will commence on 18th March.

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Substantially Compliant	Yellow	27/01/2020
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	01/02/2020
Regulation	The person in	Substantially	Yellow	31/05/2020

16(1)(a)	charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Compliant		
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	27/01/2020
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.	Substantially Compliant	Yellow	27/01/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where	Not Compliant	Orange	04/02/2020

	necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
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	04/02/2020
Regulation 29(2)	The person in charge shall facilitate a pharmacist made available under paragraph (1) in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland. The person in charge shall provide appropriate support for the resident if required, in his/her dealings with the pharmacist.	Substantially Compliant	Yellow	10/01/2020
Regulation 31(3)(a)	The person in charge shall ensure that a written report is	Substantially Compliant	Yellow	31/01/2020

	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.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, 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.	Not Compliant	Orange	31/05/2020
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/05/2020
Regulation 07(4)	The registered	Substantially	Yellow	31/01/2020

	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 practice.	Compliant		
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.	Not Compliant	Orange	31/01/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2020
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Not Compliant	Orange	31/03/2020

Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/01/2020