Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Heather Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Roscommon
Type of inspection:	Short Notice Announced
Date of inspection:	26 August 2020
Centre ID:	OSV-0004461
Fieldwork ID:	MON-0026992

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:	6

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
Wednesday 26 August 2020	09:30hrs to 16:00hrs	Noelene Dowling	Lead

What residents told us and what inspectors observed

The inspector met with five 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 but did speak with staff and reviewed the residents' support plans.

The residents could not verbally communicate with the inspectors, but did allow the inspector to sit with them and observe some of their routines and activities during the day. They were going out for their activities, having their meals and listening to their preferred music. They appeared comfortable in their home and the restructuring of the premises was seen to have a very positive impact on the overall environment for the residents, allowing greater ease of access and independence. The staff were seen to be attentive to and responsive to the residents and their care was being delivered in a dignified manner. The residents appeared well and their primary care needs were being well supported by staff. They supported them sensitively with their meals and their tasks.

The premises had been newly painted and the resident's bedrooms were personalised and comfortable.

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 in January 2020.This followed a period of regulatory actions including the issuing of a warning letter to the provider by the Chief Inspector.The centre was last inspected in January 2020. At that time the provider had mitigated the most significant risks to the residents, but non compliances were identified in areas such as such governance, staffing levels, protection, restrictive practices, adequate assessment and therapeutic supports for the residents. The provider was required to submit an updated action plan in May 2020 which identified that a number of dates for full completion of the compliance plans were extended due the COVID-19 pandemic. This was reasonable in the circumstances.

However, this inspection found that although progress had been made in most areas which improved the quality of life for the residents, findings of concern remain in relation to the overall governance and management of the service which were not satisfactory. The governance in the centre had not been stable , with two changes of persons in charge since January 2020 and a third change now in process. The post holder at the time of the inspection had responsibility for two other designated centres.While this was a temporary arrangement, the findings of this inspection demonstrate that this did not provide effective governance and operational

management of the centre. The inspector was informed that another person in charge, dedicated to this centre, was in the process of being appointed but the details had not as yet been submitted to the Chief Inspector. The findings in relation to fundamental matters, including knowledge of practices in the centre, medicines management, management of residents' finances and reviews of untoward event s, indicate that this centre has not been adequately managed. It is however acknowledged that some issues have been impacted on by the COVID-19 pandemic, subsequent restrictions and changes to practices which this necessitated.

Progress was made in some areas to improve the service delivered to residents and to better resource the centre. Following the previous inspection staffing levels had been increased to ensure there were adequate skill mix and numbers available, including locum staff, to support the residents. However, staffing levels at night time had been decreased. While not a significant risk, this did reduce the availability to support other residents when incidents occurred. There was evidence via meeting records and from speaking with staff that changes to practices, many of which were historical, had taken place, to better support the residents.

The provider had taken appropriate protective and preventative measures to deal with the COVID-19 pandemic and protect the residents. Staff rosters had been reviewed so as to decrease unnecessary footfall and risk of transmission.

From a review of the staff training records, it was apparent that the required mandatory training was being provided and scheduled for staff. There had been an improvement in this area with increased access to online training. The staff had completed training specific to COVID-19 and infection prevention and control. Staff were seen to be observing the required practices in relation to this and were able to demonstrate their understanding of the precautions necessary. From review of a small sample of personnel files, the inspector saw that the newly appointed staff had undergone the required checks.

The provider had a number of quality assurance systems implemented to monitor and oversee the residents' care. These included internal audits and provider's unannounced visits. However, although issues were identified there was insufficient evidence that these were effectively followed up on within the centre. For example, better review and recording of the use of restrictive practice, and medicine errors were identified but the findings of this inspection indicate that although noted, these were not addressed. The annual review for 2019 was available but did not include the views of the residents, or in this instance, their relatives. There were five non-compliances at the previous inspection, with six regulations found substantially compliant. Although progress had been made in most areas, none were fully addressed and these included governance, person in charge, safeguarding, restrictive practices and medicines management, which had deteriorated.

Further improvement was also required in relation to infection control practices to prevent and manage infection. These are outlined in detail on the quality and safety section of this report.

The findings from the inspection were discussed and communicated directly with the person in charge, at the close of the inspection, and with the services manager on the following day.

Regulation 14: Persons in charge

The person in charge at the time of the inspection had responsibility for two other designated centres. The findings of this inspection demonstrate that this arrangement did not provide effective governance and operational management of the centre.

Judgment: Not compliant

Regulation 15: Staffing

Staffing levels had been increased to ensure there were adequate skill mix and numbers available, including locum staff, to support the residents. However, the ratio of staff at night had been decreased, which limited the support available to the residents at that time.

Judgment: Substantially compliant

Regulation 16: Training and staff development

From a review of the staff training records, it was apparent that the required mandatory training was being provided and scheduled for staff. There had been an improvement in this matter with increased access to online training. The staff had completed training specific to COVID-19 and infection prevention and control.

Judgment: Compliant

Regulation 23: Governance and management

The systems for oversight and management of the centre were not adequate to ensure safe and suitable care for the residents.

The providers annual report did not demonstrate that residents and or families were

consulted in regard to their care.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found that the provider and person in charge was submitting the required notifications to the Chief Inspector.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The provider had submitted details of the arrangements in place for the absence of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

The person in charge advised that no complaints had been recorded on behalf of the residents.There is a detailed policy on the process should this be the case.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The contracts for the service available were not signed by, or on behalf of the residents, by an appropriate representative.

Judgment: Not compliant

Quality and safety

The previous inspection found that improvements were necessary to improve the residents' day-to-day quality of life in the centre. To this end, positive changes had been made to the residents' access to activities of choice and routines which resulted in the residents having more meaningful day-to-day experiences, and person-centred activities. The residents do not attend formal day-care but had a wrap around service. There was evidence that plans had been made to provide a more person-centred service which was based on the residents preferences and assessed needs. While due to the pandemic this had not progressed fully there was sufficient evidence of change. The internal physical environment, found to be of a poor standard at the last inspection, had been significantly improved, painted, refurbished and the lay-out altered. The residents had much freer access in their home and the inspector found a more relaxed and calm atmosphere on the day of the inspection. Staff had purchased a sensory light for a resident's room and this was seen to be a relaxing space and experience for the resident.

While access to external activities and the community had been naturally curtailed due to the COVID-19 pandemic, staff had attempted to provide local safe activities for the residents during the day, and in the house. They had also tried to maintain contact with families via technology during this time. Some safe activities were being reintroduced, based on the residents' vulnerabilities.

However, discrepancies remained within the centre as to the use and availability of resources, to ensure all of the residents had suitable access and opportunities. One of the houses was effectively divided in two. One section had full access to two vehicles during the pandemic. Given that all residents were severely restricted in movement and transport was vital for any external access, this left the area with the largest number of residents with limited access. The deployment of staff during the day was also unbalanced, which did impact on some residents having easier access to external or individual activities. In discussion with the area manager, it was apparent that this was not the intention, but this had not been addressed locally.

The garden area in one section of the premises was comfortable and nicely furnished to support and encourage the residents to avail of it, but the second area was bare, with no sensory or other equipment and was not conducive to the residents using it. These type of discrepancies, which impacted on the residents, were also noted at the previous inspection. They cannot be explained by differences in the needs of the residents.

The residents' primary and healthcare needs continued to be very well supported however, with prompt and frequent access to all necessary multidisciplinary assessments and reviews including general healthcare, neurology, speech and language, physiotherapy and mental health reviews, if via an altered format. Staff also continued to support the residents with physiotherapy exercises, during this time. Suitable support plans were devised and seen to be implemented for these assessed needs including, nutrition, choking and or falls risks.

The systems for safeguarding of residents had been improved with a more robust response to incidents of harm and adequate actions taken to address these. The

provider was seen to act appropriately and promptly to address any instance where the residents were subjected to any inappropriate or harmful action. In addition, there had been suitable closures installed on bathrooms and some bedroom doors to ensure that the residents' privacy and dignity was protected when personal care was being implemented. Intimate care plans had been revised to reflect this need for privacy and ensure that staff adhered to this.

However, there were other safeguarding matters not sufficiently addressed. Following the last inspection, the provider had initiated a process whereby legal guardianship would be sought to protect a number of residents who required such support.This process would ensure that they were protected in regard to decisions regarding their care and their financial affairs were protected.

However, in the interim, no system had been implemented to monitor and oversee the management of the residents' finances. In one instance, the inspector saw that a significant amount of money had been used to purchase items of furniture for a resident. While this was for the resident's benefit, there was no evidence of any oversight regarding this. Despite the providers policy regarding this, and the actions required following the previous inspection, no oversight of the use, access to and spending of their monies was implemented.This presented a significant risk to the resident's financial safety. All of the residents required full support with their finances. Additionally, the contract for care seen by the inspector was not signed by, or on behalf of, the resident.

There was good access to clinical supports, including psychiatry for the management of behaviours that challenged, with detailed behaviour support plans implemented. Regular reviews were evident and the resident behaviours were monitored. Despite this, some actions required were not implemented in a timely manner. For example, it was noted that a resident's lack of sleep at night time was causing distress, and periods of exhaustion. In June 2020, among other strategies,the clinical team advised a review of the night time protocol to support the resident.This review had not been undertaken by the management in the centre at the time of the inspection.

Some of the incident reports seen by the inspector were not adequately documented to demonstrate what had occurred, or how the support plans and strategies to prevent incidents had been implemented. This prevented adequate review of the incidents. Following the previous inspection the provider had implemented a process to ensure the more suitable oversight and decision making with regard to the use of restrictive practices in the centre. The rights committee, which included independent representatives had recently been reinstated. A number of these restriction were historical practices and some had been reviewed and discontinued.

However, once again, a number of the records maintained, detailing the use of such practices were poor. In one instance, the inspector was unable to ascertain from any person in the centre in the centre what restriction was being implemented. This lack of local oversight in these areas could place residents at risk of harm,

or inappropriate implementation of behaviour supports or restrictive practices.

The inspector was also concerned that some actions taken, but not completed, to reduce restrictions and improve the living experience for the residents, had resulted in other residents being negatively impacted on due to the actions not been completed. The area outside of the kitchen had been reconfigured and a push button closure system installed. The period when access would be restricted was clearly outlined for staff and was for reasonably safety reasons. This reduced the negative impact on all of the residents. Of more significance, was the fact that meal times for one resident were now a more dignified experience. The inspector observed this on the day. However, while the works had commenced some time ago, they had not been completed. Due to this delay in completion,some residents regularly had their food taken from their plates or bowls and this caused significant distress. The pandemic does not account for this delay in the works being completed and the lack of attention to the impact on other residents.

Overall, the residents were protected by the systems in place for risk management and there were individual risk management strategies implemented for pertinent issues such as falls or seizure activity. These were reviewed frequently and additional assessment and supports sourced as needed. However, the remedial works had exposed two heating /water pipes which posed a risk to residents. The person in charge was required to have this addressed. Following the inspection th person in charge confirmed that the works had recommenced and would be completed within one week.

The action in relation to the management of fire safety for residents had not been completed satisfactorily. A practice drill had taken place to simulate night time staffing levels. This was undertaken successfully. However, the inspector saw that the staffing levels involved were far higher than those available at night time. This was reported but no action was taken to address it. The physical vulnerabilities of the residents in this centre indicate that it is crucial to ensure they can be safely evacuated at night time. The matter of unsecured exit door keys had been addressed.

Medicine management practices were not reviewed fully on this inspection. However, a significant number of medicines errors, omissions or incorrect details on the administering sheets were noted. While no direct harm had come to the residents because of this, the inspector found that no adequate actions had been taken to prevent such re occurrences, despite the policy in relation to this. In fact management were not sufficiently aware of these, prior the inspection.

The provider had implemented a number of protocols and systems to prevent and control infection in response to the COVID-19 pandemic. These included protocols for staff when coming and going off duty, restrictions on visitors, training in and the use of appropriate personal protective equipment; regular temperature checks and reduction of unnecessary footfall in the centre. These had been successful in protecting the residents. Nonetheless, while the premises was clean and staff were undertaking regular sanitising, the bathrooms in the centre were not sufficiently clean to prevent infection. The pipe works and fittings in particular, were both old

and covered in dust and grime, preventing adequate sanitising.

These factors indicate a lack of attention to oversight and direction of practices in the centre at local level.

Regulation 17: Premises

While works had taken place in the premises the garden area in one was not conducive for the residents use, it contained no sensory or other equipment which might assist the residents to enjoy it in their day-to day lives.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Overall, the residents were protected by the systems in place for risk management. However, the remedial works had exposed two heating /water pipes which posed a risk to residents. The person in charge was required to have this addressed and following the inspection confirmed that the works had recommenced and would be completed within one week.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had implemented a number of protocols and systems to prevent and control infection. While overall, the premises was clean and staff were undertaking regular sanitising, the bathrooms in the centre were not sufficiently clean to prevent infection. The pipe works and fittings in particular, were both old and covered in dust and grime, preventing adequate sanitising.

Judgment: Not compliant

Regulation 28: Fire precautions

All action in relation to the management of fire safety for residents had not been completed satisfactorily. A practice drill had taken place to simulate night time staffing levels. However, the staffing levels involved were far higher than those

available at night time. This was recorded but no action was taken to address it.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The number and nature of medicine errors and lack of actions to prevent recurrences do not indicate that these systems were safe or monitored.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

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 reviews, if via an altered format. Suitable support plans were also implemented and reviewed. Positive changes had been made to the residents' access to activities of choice and routines which resulted in the residents having more meaningful experiences, and person-centred activities. Although impacted on by the COVID - 19 pandemic, there was evidence that staff were actively seeking more person-centred and therapeutic day-to-day supports for the residents. However ,at time of this inspection deployment of staff and fair access to transport was impacting on some residents daily lives to some degree.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' healthcare needs were monitored and responded to promptly.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was good access to clinical supports for the management of behaviours that challenged with detailed behaviour support plans implemented. Despite this, actions were not taken in a timely manner on the advice of the clinical team to support the

residents. The use of restrictive practices had been reduced and a more considered approach was evident. However, he records of the interventions were poor in some instances, which did not allow adequate review and monitoring of what restriction or support plan had been implemented.These factors presented a potential risk to the residents well being.

Judgment: Substantially compliant

Regulation 8: Protection

The systems for safeguarding of residents had been improved with a more robust response to incidents of harm and adequate actions taken to address these. None the less there was no system implemented to monitor and oversee the management of the resident's finances despite the need for full support with this.This resulted in a significant risk to their financial safety.

Judgment: Not compliant

Regulation 9: Residents' rights

Though the remedial works in the centre had a very positive impact for the residents overall, the non completion of some works in the kitchen/living area of the centre, resulted in inadvertently having food taken from their plates which was seen to cause significant distress. The pandemic does not account for this delay in the works being completed.The provider agreed to have this completed within one week of the inspection.

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	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not 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	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Heather Services OSV-0004461

Inspection ID: MON-0026992

Date of inspection: 26/08/2020

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	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A new Team Leader has been appointed since 17th August and is in the process of taking over the PIC role. This Team Leader/PIC supernumerary hours for governance and management of this Centre has been increased from 14 hours to 18 hours. This Team Leader is on the roster full time and this supports effective governance and management with ongoing contact with all houses in the centre and a strong working knowledge of the centre.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A risk assessment has been completed in relation to staffing levels in the house, this is under continuous review and is guiding the levels of staffing required. The Management team have reviewed staff rosters to ensure adequate staffing at all times. There is a plan in place to support a person to transition from one house to another house within the Designated Centre. This transition will ensure an adequate level of staffing for all people to meet their support needs. On the completion of this transition, a vacancy will be created and the Management team have a plan in place on how best to fill this vacancy, based on the needs of individuals.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A new Team Leader has been appointed since 17th August and is in the process of taking over the PIC role. This Team Leader/PIC has 14 hours' supernumerary for governance and management of this Centre. This Team Leader is on the roster full time	

and this supports effective governance and management with ongoing contact with all houses in the centre and a strong working knowledge of the centre.

The appointment of the Team Leader further supports effective governance and management with ongoing review of quality assurance systems. All actions from the provider's internal review have been completed.

The providers annual review stated that the views of the people supported and their families where applicable were sought via questionnaires but on this occasion no completed questionnaires were returned from families. However staff and management from the centre are in regular contact with families.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Application for Ward of Court has commenced to ensure there is oversight of decision making for people supported.

While this is in process, a Social Worker is supporting the staff and management of the Centre with decision making for the people supported.
Therefore, the service of contract is being reviewed with the support of this MDT input.

A referral has been made to the National Advocacy Service to ensure there is further oversight and support for decision making with people supported.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A plan is now in place for upgrading and development of the garden space to ensure that all areas at the back of the house are accessible for all people supported.

Funding is being sought to purchase sensory equipment for the garden space and to create a sensory area.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Remedial works are now completed with photo evidence sent to inspector.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The pipes in the bathroom are now cleaned, covered and painted.

A daily cleaning schedule and checklist is in place to ensure maximum safety and infection control. All staff have completed Infection Prevention and Control training and are now also completing the HIQA digital learning module on infection prevention and control.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Manager and Team Leader have a comprehensive plan in place to ensure the safe evacuation of all people supported with minimum number of staff and maximum number of people supported. Further fire drills have been completed including night time evacuations. All individual Emergency Plans have been reviewed and updated.	
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 review of Medication management in the centre has been conducted by manager and Team Leader. A number of new measures have been implemented. This involves a system of daily stock checks of medication which is monitored by team leader weekly. This is in place for an initial period of 3 months. This system will be reviewed then with a view to moving to weekly stock checks. Signage and information has been placed in the areas of medication administration to remind all staff of best practice in medication management. All staff are scheduled for Safe Administration of Medication refresher training. The manager and team lead have anaylsed the medication errors and these will be reviewed by the medications errors management group. The organisation has a system for analysis of all medication errors by a medication errors group on a quarterly basis. The Team Leader will be reviewing all errors on an ongoing basis with a review at quarterly team meetings.	
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: All staff have been informed and are aware that there are two cars available for all people supported and there is fair access to transport. All staff are aware that they can access the transport in an equitable manner for all people supported. Team Leader has discussed this with staff and is monitoring transport use by staff.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive	

behavioural support:
The restrictions recording has been reviewed to ensure that all restrictions are legible when recorded.
The Team Leader /PIC is reviewing restrictive practice and continuing to review the ability to reduce restrictions in place in the centre.
All restrictions are reviewed and anaylsed on a quarterly basis.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The service has appointed a person who will manage and oversee the systems for person supported monies.
There is a system in place which will be strengthened with specific guidelines to support the decision-making on spending for people supported in the Centre.
There will also be a review of the policy in relation to this.
There is an asset register in place for people supported.

To further strengthen oversight of decision making, there is also an application for a Ward of Court, which has commenced.
While this is in process, a Social Worker is supporting the staff and management of the Centre with decision making for people supported.
A referral has been made to the National Advocacy Service to ensure there is further oversight and support for decision making with people supported.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Remedial works are now completed with photos evidence sent to the inspector.

The remedial works were required in one house in the centre, as a result of eliminating an environmental restriction. By removal of this environmental restriction, it ensures all people supported had full and equal access to their kitchen. Reduction of restrictions continues to be reviewed by the Team Leader.

A Risk Assessment and protocol has been put in place to support individualised meal times and ensure that each person has an individualised plan in place based on all people’s support needs.

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	05/10/2020
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	05/10/2020

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.	Substantially Compliant	Yellow	28/09/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/01/2021
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	05/10/2020
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	05/10/2020
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their	Not Compliant	Orange	05/10/2020

	representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
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.	Substantially Compliant	Yellow	21/09/2020
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	31/10/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all	Substantially Compliant	Yellow	28/09/2020

	persons in the designated centre and bringing them to safe locations.			
Regulation 29(4)(b)	The person in charge shall 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.	Not Compliant	Orange	30/11/2020
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).	Substantially Compliant	Yellow	28/09/2020
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	Substantially Compliant	Yellow	21/09/2020

	accordance with national policy and evidence based practice.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	28/09/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/11/2020
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	28/09/2020