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:	Fuchsia Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Roscommon
Type of inspection:	Unannounced
Date of inspection:	16 October 2019
Centre ID:	OSV-0004471
Fieldwork ID:	MON-0027949

About the designated centre

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

Fuchsia Services consists of three houses and provides a residential service to 13 adults with a primary diagnosis of intellectual disability and who require mild to severe support needs. The centre can also support residents with mental health needs and one house provides a service to adults of a senior age. Residents in this house are facilitated to remain at home in line with their wishes and attend day services at their leisure. Two of the houses are located within walking distance of a medium sized town and one house is located in a rural setting. Each house is provided with transport, one of which is wheelchair accessible and residents generally attend day services from Monday to Friday. A social model of care is provided in this centre and residents are supported by a combination of social care workers, care assistants and community connectors. Residents are also supported at night by a staff member in each house on a sleep-in arrangement. An additional sleepover staff has been employed in one unit in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
16 October 2019	09:30hrs to 19:00hrs	Anna Doyle	Lead
16 October 2019	10:00hrs to 19:00hrs	Sarah Barry	Support

What residents told us and what inspectors observed

The inspectors only visited one of the units in this centre. Residents in the other two units were attending day services until 5pm on the day of the inspection.

The six residents residing in this unit were met by inspectors. Three of the residents were getting ready to attend their day services and three residents were remaining home. One resident appeared very happy about attending the day service.

One resident showed an inspector their bedroom and told the inspector that they had recently got a shelf in their bedroom to store some of their personal belongings. They were very happy with this. They spoke about some of the activities they liked to do and explained that they were an active member of the local tidy towns committee. They also spoke about being involved in some of the daily tasks involved in keeping their own home tidy. It was also evident that maintaining family links was very important to this person and staff engaged with the resident explaining how they did this.

The resident also said that they liked their home and explained that they had lived in a number of homes that they were not happy in prior to moving to this home.

Residents appeared comfortable with the staff on the day of the inspection. Staff members engaged well with the residents and assisted an inspector to communicate with one of the residents.

Residents spoke positively about staff and liked having the same staff. They spoke about having a choice to stay at home during the day if they preferred. One resident spoke about their favourite TV show and how this was something they enjoyed watching.

The three residents who remained home were observed doing some activities which included drawing, knitting, listening to music and were in the kitchen with staff while they prepared lunch.

Capacity and capability

This centre was not adequately resourced or managed to ensure that residents received a safe quality service. The governance and management systems in place were not effective and a lack of managerial oversight in the centre was not assuring that practices were monitored and reviewed to ensure that residents were safe at all times. The provider had also failed to ensure that staffing arrangements were

meeting the needs of the residents.

Since the last inspection in June 2018, twelve notifications had been submitted to the chief inspector relating to incidents where there were injuries to residents. Eight of these related to one unit in particular. Some of the information contained in the most recent notifications indicated concerns around the staffing levels and governance and management systems in the centre.

As a result, the provider was required to respond and provide assurance reports regarding appropriate staffing and governance and management arrangements in the centre. The provider was given two opportunities to respond to the concerns raised. The initial response from the provider did not adequately address the issues of concern. The identified concerns were then raised with a member of the providers' senior management team. This member was also given the opportunity to respond to the concerns that had been raised. Both responses to the chief inspector failed to provide necessary assurances and concerns regarding residents' wellbeing remained. Following a series of escalation steps it was agreed that an unannounced risk based inspection would be carried out.

This risk based inspection found that governance and management arrangements were not effective. The inspectors were not assured that the person in charge could maintain effective governance and oversight of this designated centre.

The person in charge was responsible for two other designated centres and another community home and was responsible for the supervision of a large number of staff. Both the person in charge and a staff member verified that the person in charge only visited the centre on a monthly basis, staff meetings were only conducted every three months and supervision of staff was not being consistently implemented. The inspectors also found that the person in charge was not informed of all the care interventions in place for residents in a timely manner. This meant that staff were not always provided with the appropriate supports/guidance to support residents. This was observed on the day of the inspection. The system in place to ensure that all staff who worked in the designated centre had the necessary skills/training in order to support the residents' needs required improvement.

This lack of oversight had been highlighted to senior managers by the person in charge a number of times, dating back to May 2019. While the provider had initiated a process to seek an additional team leader for this centre, no interim measures or supports had been implemented to address the situation at the time of inspection. The inspectors found that this lack of oversight; along with inadequate resources was contributing to poor outcomes for residents and as a result the provider was issued with an urgent action plan the day after the inspection requiring them to put steps in place to ensure risks were managed and residents were safe from harm. While the provider submitted an action plan response outlining how they had addressed this, concerns still remained as the response was not comprehensive and did not address the issue regarding staffing arrangements and the arrangements for supporting residents at risk of injury. As a result the provider was invited to attend a meeting in HIQA's Smithfield Offices where the findings of the

inspection were explained in more detail and a warning letter was issued.

Staffing arrangements required review and the skill-mix was not appropriate to meet the residents' needs in a safe manner. The person in charge and the provider had identified this themselves as a result of the changing health care needs of the residents. The provider had responded by initiating a process to seek funding for a waking night staff in one unit in order to meet the residents' needs. The provider had also indicated that they intended to change the model of care to a nurse led model given the residents' needs in this unit. This had not been put in place at the time of this inspection and the provider had not put any interim measures in place until the day before this inspection, despite the their ongoing concerns for residents' safety at night and their inability to safely evacuate one resident at night should this be required. This was not an adequate response on behalf of the provider.

The interim measure that was put in place; was for an additional sleep over staff to be present in the centre. However, the inspectors found that some residents required monitoring at night time due to their specific needs and it was not clear how the addition of a sleep over staff could ensure this (given that there were no waking overnight staff in this part of the centre). For example, on review of a number of documents some residents who had bed-rails were not being monitored at night time, one resident who was prescribed medication that required monitoring vital signs post administration could not be monitored should this occur after the hours of 23.30hrs. There was also no on-call support provided to staff after these hours in order to get advice, guidance or additional supports if required.

The inspectors also found that residents’ needs could not always be consistently met during the day. When residents chose to remain home from their day services they were supported by day service staff in the designated centre. On the day of the inspection three residents had remained home (one of whom was unwell). Two day service staff were allocated to support these residents. It was observed during the inspection that only one staff member was present for a one and a half hour period even though one resident required the support of two staff for some of their care needs”. During another period two residents who were identified as being at risk of falls, one of whom was also at risk of wandering off, were left unsupervised while staff attended to the other residents' needs.

The provider had not ensured that staff had the required level of knowledge to keep residents safe. The staff spoken with did not demonstrate adequate knowledge of residents' need for supervision and support. Similarly, some were unsure about the interventions in place to support all of the residents' care needs. The inspectors found that, given the changing needs of the residents (some of whom had complex health-care needs), this was not providing continuity of care to the residents and did not support a safe service.

There was a planned rota in the centre; however, the actual rota maintained was incomplete in places and it was not always clear who had completed shifts in the centre. The person in charge could not verify this either. The inspectors also found that the person in charge did not have oversight of the staff rotas in the centre or staff annual leave. This had been highlighted to senior managers on two separate

occasions and no actions had been taken to address this. It was therefore unclear how the person in charge could ensure that the needs of the residents were being met by a skilled, competent workforce at all times.

Staff had been provided with some training requirements in safeguarding vulnerable adults, manual handling, supporting people with behaviours of concern and the safe administration of medication. Some staff were due refresher training and the person in charge provided dates when this was scheduled to take place.

However, no training had been provided to staff on the use of one medical device used to care for a resident and not all staff had completed training in CPR (despite this being a control measure listed in a risk assessment viewed for a resident).

The governance structure did not support clear lines of responsibility and accountability for the safety and quality of care. It was not clear who was accountable for the care and support of residents during the day when day service staff were employed. For example, on the inspection staff were asked to clarify who they would report issues that arose regarding a broken wheelchair for one resident and to seek guidance around the healthcare needs of another resident. Staff said they reported directly to the day service manager and not to the person in charge of the centre.

The provider had some systems in place to monitor the services provided but given the findings of this inspection it was evident that these systems were ineffective. An annual review had been conducted for 2018. However, the provider had not completed the six monthly unannounced quality and safety reviews as required under the regulations. The last one was conducted in June 2019 (previous to this it had been May 2018). Areas of improvement identified from the review conducted in June had not been addressed, some of which included, fire safety concerns, staffing arrangements and the provision of wheelchair accessible transport.

Overall, the inspectors were not satisfied with the governance and management systems in place in this centre and were concerned that residents' needs were not being fully met given the significant failings identified at this inspection.

Regulation 14: Persons in charge

The person in charge was suitably qualified and had experience working in the disability sector, including having held a number of managerial roles.

The provider had not ensured that the arrangements for the person in charge allowed them to have adequate oversight of the centre.

Judgment: Not compliant

Regulation 15: Staffing

Staffing arrangements were insufficient during the day and at night to ensure that residents' needs could be safely met.

As identified by the provider, the skill-mix in one unit required review in order to ensure that residents' needs were being met.

There was no on-call support provided to staff after the hours of 11.30pm at night in the centre.

The person in charge did not have oversight of the staff rota or planning of staff leave in the centre.

The actual rota in the centre was not properly maintained.

Residents were not being provided with continuity of care during day when they chose not attend day services.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not being formally supervised in the centre.

Staff had been provided with some training requirements in safeguarding vulnerable adults, manual handling, supporting people with behaviours of concern and the safe administration of medication. Some staff were overdue refresher training and the person in charge provided dates when this was scheduled to take place.

However, staff had not received training in first aid, or been provided with guidance or skills to support some residents' assessed needs in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The centre was not adequately resourced to ensure that residents' needs could be met.

The governance and management arrangements did not ensure effective oversight of the care and support needs of the residents.

The provider had not conducted the unannounced reviews every six months as required under the regulations.

The provider was not responding appropriately to risks identified in the centre through their own auditing practices.

The reporting structures in place when day services staff were in the centre required review.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose containing the information set out in Schedule 1 of the regulations, this had been reviewed in January 2019.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had notified HIQA of any adverse incidents that had occurred in the centre as required under the regulations.

Judgment: Compliant

Quality and safety

The inspectors found that the quality and safety of care being provided in the centre required significant review in all of the regulations inspected under the dimension of quality and safety. As already stated earlier in this report the provider was issued with an urgent action plan following the inspection to submit assurances around fire safety and risk management systems in the centre. Significant improvements were also required in personal plans, health care, infection control, positive behaviour

support and medication management practices.

Residents had personal plans in place. A review of a sample of these found that a health care assessment of need had not been conducted for a resident who had been admitted to the centre 12 weeks prior to this inspection. There were also no plans in place to guide how this resident should be supported with all of their identified health-care needs. The person in charge confirmed that not all support plans were in place for another resident when they could not be found on the resident's plan. While staff were observed to be doing their best to support the residents in the centre, they were not fully informed around some of the residents' needs. For example; one resident had a medical investigation conducted recently regarding monitoring their health and staff spoken with were not aware of additional support required for the resident.

The person in charge had also only been made aware of a new medicine prescribed for a resident the day before the inspection despite this being prescribed two weeks prior. This medicine was administered using a specific medical device. However, some of the staff were not shown how to use, maintain or clean this equipment. This was concerning as it also posed a risk of infection to the resident if the equipment was not cleaned properly.

The inspectors found that residents had timely access to GP services and some allied health professionals. However, one resident had not been assessed by an occupational therapist as recommended from a review of their care. The recommendations following a review conducted by another allied health professional in April 2019, had also not all been implemented for a resident which outlined better, safer ways to support this resident.

Staff informed inspectors that a meeting had been held recently for a resident who was being supported to develop an end-of-life care plan with the support of staff and relevant family members.

On review of the fire safety systems in place, inspectors found that the evacuation procedure for the centre did not guide practice. Since March 2019, senior managers were aware that at least one resident could not be safely evacuated from the centre when only one staff was on duty at night time. This was also highlighted during two fire drills that had taken place in 2019 where two residents had not evacuated due to only one staff member being on duty. The provider had only responded to this the day before this inspection when an an additional sleepover staff was introduced. A fire drill had not be conducted nor was it planned since the introduction of the second sleepover staff. Therefore, the provider had not assured themselves that residents could be safely evacuated.

The personal emergency evacuation procedures had also not been updated to reflect learning from those fire drills; therefore, it was not clear what staff should do to safely evacuate the residents in the event of an emergency evacuation.

Fire fighting equipment was examined in one building in the centre. This equipment had been inspected by a professional company this year. The fire detection and

alarm system and the emergency lighting had also been inspected recently.

The inspectors were also not assured that the risk management processes in the centre were effective. The provider had not ensured that the needs of one resident could be met in the centre as there was not enough staff at night prior to this resident being admitted to the centre. This risk had been highlighted through a number of forums to senior managers and had not been addressed prior to the resident being admitted to the centre.

Risk assessments were not all recently reviewed despite the provider submitting assurances to the Chief Inspector prior to this inspection that all risks had been reviewed in the centre. For example, a falls risk assessment for one resident dated April 2018 had not been reviewed even though this resident had sustained a fall in August 2019. A sample of other risk assessments for this resident found that some had not been reviewed since March 2019. Similar findings were evident in other risk assessments reviewed by inspectors.

Another resident with a history of seizures which required interventions in the past six months had a risk assessment pertaining to this reviewed in October 2019. Control measures listed to mitigate risks at night included the use of a sensor mat in the resident's bed. However, given the resident's usual night time routines this sensor would not alert sleepover staff in the event of a seizure when the resident was not in bed.

A separate risk register documented other risks pertaining to the centre. The risk register had been reviewed recently(15 October 2019) . However; inspectors found that some hazards were not risk rated appropriately. For example, fire was risk rated at 'four' meaning it was classed as a low risk. Another risk assessment (choking) listed a control measure to mitigate risk as being that all staff were trained in First Aid. This was not evidenced from the training records viewed by the inspectors as discussed earlier in the report. Therefore, it was not demonstrated that the provider's policies and procedures for risk management were being followed and implemented consistently.

An environmental analysis report (as mentioned earlier) had been conducted in April 2019 by an allied health professional for one resident with recommendations to support this resident. Some of the recommendations made may have prevented falls for this resident. Not all of these had been implemented and were not included in the residents' risk assessments.

There were two vehicles in the centre. Neither of which were wheelchair accessible. This had been raised at the unannounced quality and safety review. This meant that one resident could not access the community unless an accessible vehicle is borrowed from another service or a wheelchair taxi is used. While the service was paying for the taxi if one was needed the provider had not progressed this issue since June 2019.

Staff had been provided with training in supporting people to manage behaviours of concern. However, a resident who required support in this area had no plans in place to guide staff on how to support this resident. This included a guide on when

to administer a chemical restraint in response to these behaviours.

This was particularly concerning as this resident had been administered a chemical restraint in response to some of these behaviours on four occasions in the last month. It was also noted that this resident had to be discontinued off some similar prescribed medication in August 2019 as it had made them unsteady on their feet and had resulted in a fall. This meant that there was no guide in place to ensure that the least restrictive measure was used to support this resident at all times in a safe manner.

Other restrictive practices were used in the centre and these were being reported to HIQA in line with the requirements under the regulations. However, two of these restrictive practices had not been reviewed and approved by the organisation's own Human Rights Committee. An assessment had not been conducted for one resident who required a bed rail to identify the rationale for its use and assurances were not in place as to why this restrictive practice was not being monitored throughout the night in line with best practice.

Medication management practices were reviewed in the centre. On review of the storage of medication, inspectors found that a medication prescribed for a resident was dispensed in both blister packs and in a labelled container in the medication press. Both medications had been dispensed from a pharmacy within the last month. This posed a potential serious risk to the resident if both doses were administered to the resident. Inspectors requested the staff member to address this and outlined the concerns to the person in charge. The person in charge informed inspectors that the medication had been removed prior to the end of the inspection.

A number of other poor practices were identified. Some medications had not been signed by staff as being administered and had not been recorded as a medication error. Some medicines stored were not labelled correctly. Medicines received and stored in the centre were not always recorded as per the service policy.The times of administration of one medication did not match the times on the blister pack provided and staff could not verify the correct times for administration. Out of date or unused medication was not segregated from other medication and had not been returned or disposed of. One such medicine had been discontinued since September 20 2019.

Inspectors also found that some medicines which were prescribed PRN (as required) for the management of pain, was not in stock in the centre should residents require it.

Regulation 26: Risk management procedures

The risk management processes in the centre required overall review. The provider had not ensured that the needs of one resident could be met in the centre as there was not adequate arrangements at night prior to them being admitted to the centre. This risk had been highlighted through a number of forums to senior managers and

had not been addressed prior to the resident being admitted to the centre.

Residents' individual risk assessments had not been reviewed.

Some of the risk assessments did not outline all of the control measures in order to mitigate risks.

The risk register which outlined some control measures to mitigate risk in relation to choking required review.

One risk assessment had not been updated to include recommendations made to mitigate the risk of falls and these recommendations had not been implemented.

Judgment: Not compliant

Regulation 27: Protection against infection

Staff were not knowledgeable about the maintenance or cleaning procedures for a medical device that was being used in the centre. This could pose an infection control risk.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire evacuation procedure for the centre did not guide practice.

An emergency evacuation procedure for a resident had not been updated to reflect the learning from a fire drill and there was no plan in place to guide staff regarding what they would do to ensure the safety of this resident in the event of an emergency evacuation.

Until the day before the inspection one resident could not be safely evacuated from the centre as only one staff was available at night. The provider had been aware of this since March 2019.

A night time drill had not been conducted or planned to assure that all residents could be safely evacuated from the centre at night.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication prescribed for a resident was dispensed in both blister packs and in a labelled container in the medication press. Both medications had been dispensed from a pharmacy within the last month. This posed a potential serious risk to the resident if both doses were administered to the resident. The person in charge informed inspectors that the medication had been removed prior to the end of the inspection.

Medications had not been signed by staff as being administered and had not been recorded as a medication error.

Some medicines stored were not labelled correctly.

Medicines received and stored in the centre were not always recorded as per the service policy.

The times of administration of one medication did not match the times on the blister pack provided and staff could not verify the correct times for administration.

Out-of-date or unused medication was not segregated from other medication and had not been returned or disposed of. One such medicine had been discontinued since September 20 2019.

Some PRN (a medicine to be taken as required) prescribed medication for the management of pain, was not in stock in the centre should residents require it.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A health care assessment of need had not been conducted for a resident who had been admitted to the centre 12 weeks prior to this inspection.

The provider did not have the supports in place prior to this resident being admitted to the centre in order to meet their needs.

There were no plans in place to guide how residents should be supported with all of their identified needs.

Staff were observed to be doing their best to support the residents in the centre, they were not fully informed of some residents' needs. For example; one resident

had a medical investigation conducted recently regarding monitoring of their health and staff spoken with did not have up-to-date information regarding additional ongoing supports required for the resident.

Transport arrangements for residents to access the community required review.

Judgment: Not compliant

Regulation 6: Health care

Residents did not have timely access to an occupational therapist.

Recommendations from a review conducted by an allied health professional had not all been implemented. This included recommendations to support this resident to manage a recent diagnosis which would impact on this residents quality of life.

Judgment: Not compliant

Regulation 7: Positive behavioural support

A resident who required support with some behaviours of concern had no support plans in place to guide staff on how to support this resident. This included a guide on when to administer a chemical restraint.

The assessment, monitoring and review of restrictive practices required significant review in the centre to ensure that residents were safe, that restrictions were used as a last resort and that they were the least restrictive measure employed to support residents.

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
Capacity and capability	
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	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	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	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Fuchsia Services OSV-0004471

Inspection ID: MON-0027949

Date of inspection: 16/10/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The registered provider has submitted a business case to the external funding body on 21/3/2019 for additional funding to recruit a new Team leader/PIC to the designated centre. This newly appointed Team leader/PIC will work frontline duties as well as having supernumerary hours to ensure adequate oversight of the designated centre. The external funding body are due to carry out a review of the DC on the week commencing 2nd of December 2019. The inspector has reviewed the provider's compliance plan. The action proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider submitted a business case to the external funding body on 21/3/2019 seeking additional funding to enhance staffing resources due to the changing needs of the persons supported in the the designated centre. The external funding body are due to carry out a review of the designated centre on the week commencing 2nd of December 2019. Staff are on duty until 11.30pm and members of management team are On-Call until 11.30pm. The services provided are a community based model and seek to replicate the generic norms within the community.	

A new rostering system is being introduced within the service and this will help the PIC have a better oversight of the staff rota in the designated centre and all future planning of leave in the centre.
The PIC has reviewed and amended the designated centre's rota ensuring that it is properly maintained at all times.
All staff are fully inducted to work in day and residential settings. Staff in question working in the house were inducted to support the people during the day and the evening. All staff receive the relevant necessary training and are deemed to be competent to work in both day and residential setting.

The inspector has reviewed the provider's compliance plan. The actions proposed to address the regulatory non-compliance do not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The PIC has scheduled supervision dates with all of the staff in the centre and has held two Team Support & Supervision meetings with the staff on the 6th and 20th of November 2019.
First Responder CPR/AED training completed for all outstanding staff members on 25th November 2019.
Additional Choking "Foreign Body Obstructive Airways" training scheduled for all staff on 17th December 2019.
FEDS assessments are being carried out for all identified people supported. Staff have been scheduled for FEDS training on the 17th December 2019.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider has submitted a business case to the external funding body on 21/3/2019 for additional funding to recruit a new Team leader/PIC to the designated centre. This newly appointed Team leader/PIC will work frontline duties as well as having supernumerary hours to ensure adequate oversight of the designated centre. The

external funding body are due to carry out a review of the designated centre on the week commencing 2/12/2019.

The inspector has reviewed the provider's compliance plan. The action proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The overall risk management process has been fully reviewed by the PIC and team. All of people supported's individual risk assessments and the designated centre's risk register have been reviewed by the PIC, MDT and the staff team outlining all of the control measures in order to mitigate risk.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The PIC and team have developed a protocol for the use of this medical device. All staff are now familiar with it's cleaning, maintenancee and procedures in terms of infection control.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The fire evacuation procedure for the centre and all of the PEEPs have been reviewed and updated by the PIC and the staff team as of the 17th of October 2019. The fire evacuation procedure now guides practice.
Four night time fire drills have taken place in the designated centre since the monitoring inspection on 16th October 2019 ensuring that all people supported can be safely

evcuated in a timely manner. Regular night and day time fire drills are planned in line with best practice.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The PIC has reviewed all medications prescribed and is assured that all medications are administered as prescribed to the person for whom they are prescribed and to no other person.
To ensure this, the following actions have been completed by 12/11/2019.

Medication audit carried out in the designated centre on 08/11/2019 and actions from this include the following:

All out of date/unused medication has been returned to the pharmacy.

These medications have been logged out, and signed off by pharmacist using medication log book.

All medications are labelled accordingly and correspond with medications prescribed on the medication administration record.
All Medication held in the blister packs correspond with the medication administration record.
All medication errors have been documented.
All PRN medications are in stock as prescribed on the medication administration record.
All staff have up to date SAMs training.

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 assesment of need used by the organisation is the Personal Outcomes Measures plan and this has been completed. An Annual Medical Review was also completed on the 19/08/2019 by the person supporteds GP.
All of the people supported's Personal Outcome Measures Plans and Health Support Plans have been reviewed in full to include all identified needs. All staff are now fully informed

of all of the persons supported identified needs.
Alternative transport arangements are being explored from within the current fleet of transport vehicles within the service.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The PIC had made a referral to the community HSE Occupational Therapist on October 10th 2019 August and is still awaiting a response.
All of the recommendations of the Health Psychologist's review had been implemented on the 07/06/2019 with the exception of one at the time of the inspection. While the inspectors did not have sight of the completed action plan, the actions were complete except one which has since been completed on 20/10/2019.

The Health Psychologist has met with the PIC on the 12th December 2019 and has reviewed the recommendations of the environmental assessment. This has resulted in some changes to the actions required. The majority of the recommendations were actioned by the 20.10.19 and all outstanding actions internally to the house including the taps and handrails will now be completed by 31.1.20.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
It is the policy of the organisation to use the least restrictive measures and refer all restrictions to the Human Rights Review Committee for independent review. The Postive Behaviour Support policy and the Human Rights and Protection Promotion policy guide the use of least restrictive practices within the designated centre. All restrictive practices are assessed, monitored and reviewed by the organisation's Human Rights Review Committee.
The person supported here has been referred to the organisation's Behavioural Support team and the use of a chemical resraint has also been referred to the Human Rights Review Committee. The PIC has ensured that there is a clear protocol in place to guide staff on when to administer a chemical restraint.

Bed rail protectors (bumper bars) were fitted on 11.11.19.
A risk assessment on the use of bed rails is completed. A daily monitoring checklist has been put in place. This ensures that bed rails positional locking mechanisms and bed

height adjustments are functioning correctly, bed rail protectors are positioned correctly to meet the health and safety needs of the person supported.

Staff will monitor the bedrails when in use up until 23:30 pm. There is currently no monitoring in place from this time until 7:30 am as there is currently no waking night staff.

The registered provider submitted a business case to the external funding body on 21/3/2019 seeking additional funding to enhance staffing resources-waking night hours. The external funding body carried out their own independent review of the designated centre on the 4th of December 2019. The registered provider is awaiting a response and cannot give any date for completion of this action at this time.

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(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	
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	Red	27/10/2019
Regulation 15(2)	The registered	Not Compliant		

	provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.		Orange	
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	27/10/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	27/10/2019
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	17/12/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	20/11/2019
Regulation	The registered	Not Compliant		

23(1)(a)	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.		Orange	
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	
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	
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least	Not Compliant	Orange	31/12/2019

	once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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	Red	23/10/2019
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	Not Compliant	Orange	20/11/2019

	Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	23/10/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	23/10/2019
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	23/10/2019
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	Not Compliant	Orange	12/11/2019

	medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Red	12/11/2019
Regulation 05(1)(a)	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 prior to admission to the	Not Compliant	Orange	23/10/2019

	designated centre.			
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	23/10/2019
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	23/10/2019
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	28/10/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each	Not Compliant	Orange	20/10/2019

	resident, having regard to that resident's personal plan.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	20/10/2019
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	29/10/2019
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.	Not Compliant	Orange	29/10/2019
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's	Not Compliant	Orange	29/10/2019

	behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.			
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	29/10/2019