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:	Kingfisher 1
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	09 October 2019
Centre ID:	OSV-0004836
Fieldwork ID:	MON-0023389

About the designated centre

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

Kingfisher 1 provides a full-time residential service for up to 11 adult residents of varying age, with an intellectual disability. The designated centre aims to provide residents with a safe and homely environment in Limerick. The designated centre comprises of two community houses. Both houses are two storey buildings, providing residents with their own bedroom. One house has a single bed-sit and a single apartment attached to the house. The residents are supported in their home by social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
09 October 2019	08:30hrs to 17:30hrs	Lisa Redmond	Lead

Views of people who use the service

On the day of the inspection, the inspector had the opportunity to meet and interact with nine residents living in the designated centre. The designated centre comprised of two community houses. The inspector had the opportunity to meet residents living in both community houses.

The inspector visited four residents living in one of the houses on the morning of the inspection. Residents were observed preparing for the day ahead, with supports provided by one staff member. The residents told the inspector that they liked their home and that they knew the staff members who supported them in the designated centre. It was evident that the residents were comfortable in the presence of the staff members. It was also evident that residents were comfortable in the presence of each other, and they told the inspector that they were good friends.

One resident told the inspector that they did not want to move house. The inspector explained the purpose of the inspection to the resident. The resident informed the inspector that they had retired from day services and that they were supported to stay in their home during the day. Residents informed the inspector that they relaxed while they were in the designated centre. Another resident spoke about going shopping. Residents also spoke about attending monthly socials, where they met their friends from day services and friends who lived in other designated centres.

The residents were aware of the evacuation procedure, and they told the inspector about evacuating the centre during fire drills. One resident told the inspector that they were going to visit family members for the weekend in Galway. Another resident spoke about visiting Galway on a holiday they had taken some years ago. The resident told the inspector that they would like to go on a holiday again in the future.

The inspector visited five residents living in the other community house on their return from day services. The residents told the inspector that they liked their home and that they were friends. One resident told the inspector that the house needed to be painted and decorated.

Residents were aware that they could talk to staff members and the person in charge if they had an issue. The residents told the inspector that they spent their time relaxing when they were in the designated centre. One resident told the inspector that sometimes they cannot go on social outings with the designated centre when another resident declines to go. The resident also told the inspector that they would like to go on a holiday.

Capacity and capability

The inspector reviewed the capacity and capability of the designated centre and found that a number of improvements were required to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

There was a clearly defined management structure in the designated centre that identified the lines of authority and accountability for all areas of service provision. The designated centre had appointed a person in charge. This individual held the necessary skills, qualifications and experience to fulfil the role. However, it was evident that the person in charge was not correctly informed of the actions taken by senior management, in response to adverse events affecting residents living in the designated centre. During the inspection, the inspector was provided with incorrect information about the safeguarding measures taken to ensure that residents were safe, and the status of complaints made in the designated centre. After the inspection, it was recognised by the registered provider that the person in charge had not been appropriately informed and updated about the status of these issues.

The designated centre was not adequately resourced to meet the assessed needs of residents. One staff member was on duty on a sleepover shift from 4.30pm until 9.30am on weekdays, in each of the two community houses. At the weekends, staff members were on duty at all times, on a sleepover shift. The person in charge informed the inspector that two business cases had been submitted to request funding to provide increased supports for residents; however no progress had yet been made. One business case had been submitted to request extra staffing to ensure that residents in one of the community houses were adequately safeguarded from potential abuse. The person in charge had attempted to mitigate the risks associated with the lack of staffing resources. The person in charge had re-located their office to the community house. An on-call support worker had also been put in place to provide supports to residents. However, the person in charge acknowledged that this support was only in place on alternative evenings and weekends, and that the on call support worker was regularly called away to work in other areas of the organisation.

The second business case had been submitted to provide additional staff supports to one resident who no longer attended day services. Support from day services had been put in place for one hour each day to facilitate meal times with the resident. However, sufficient action had not been taken to support this resident in line with their assessed needs. This will be further discussed in this report under quality and safety.

The inspector spoke with a number of staff members who work in the designated centre. Staff members spoken with highlighted their concerns about the staffing levels in place in the designated centre. The staff members spoke about the impact of the staffing levels on residents' participation in activities, holidays and cleanliness of the designated centre. Staff members told the inspector that it was difficult to

support residents to go on social outings. The staff members told the inspector that one resident regularly refuses to participate in social activities, due to their assessed needs. This regularly impacts on the other residents' ability to access the community. The inspector viewed the complaints log and found a number of complaints made by residents, stating that they they cannot go on social outings when another resident declines to go. This complaint had been made by residents on a number of occasions. On the day of the inspection, residents told the inspector that this happened regularly. Staff members identified that they attempt to bring residents on social outings when the on call support worker was on duty. However, this support was not consistent, due to the on call support worker regularly being requested to provide supports in other areas of the organisation. It was evident that the measures put in place were not sufficient to ensure that supports provided to residents were in line with their assessed needs. This will be further discussed in this report under quality and safety.

The person in charge told the inspector that there were no open complaints in the designated centre. The inspector reviewed a complaint made by a family member on behalf of a resident. In this complaint, it was evident that the complainant was not satisfied with the outcome of the complaint. The person in charge told the inspector that the complaint had been closed. However, there was no documented evidence that the complainant had been informed about the outcome of their complaint or details of the appeals process. Following the inspection, the registered provider acknowledged that they had not followed the organisation’s complaints procedure in dealing with this complaint. The registered provider also acknowledged that the person in charge was not in a position to inform the inspector about the correct status of the complaint made because this had not been communicated to them by senior management. Assurances were received after the inspection, setting out the actions that the provider was planning to take to ensure that all complaints were investigated appropriately, and that the person in charge would be correctly informed of the status of formal and informal complaints relating to the designated centre.

Due to the issues identified in this report, and given the number of not compliant findings identified during the inspection, the inspector was not assured that the provider could ensure the effective governance, operational management and administration of the designated centre.

Two training records were in place in the designated centre, which provided details of the trainings completed by staff members and those that were scheduled. It was noted that all staff had received mandatory training in fire safety, managing behaviour that is challenging and the safeguarding of vulnerable adults.

The inspector reviewed the restrictive practices in place in the designated centre. It was evident that the restrictions in place had been notified to the office of the Chief Inspector, in line with regulatory requirements. The inspector spoke with the person in charge who had a good knowledge of the events which require notification to the office of the Chief Inspector.

Regulation 14: Persons in charge

The person in charge held the skills, experience and qualifications necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that the number of staff was appropriate to the number and assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The registered provider had ensured that staff had access to appropriate training, including refresher training, as part of a continuous professional development programme.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not ensured that effective management systems were in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all incidents were notified to the office of the Chief Inspector in line with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had not ensured that all complaints were investigated promptly. There was not sufficient evidence that the complainant was informed about the outcome of their complaint and details of the appeals process.

Judgment: Not compliant

Quality and safety

The inspector reviewed the quality and safety of care and supports provided in the designated centre and found that a number of improvements were required.

The inspector completed a walk around both houses in the designated centre. Although one of the community houses had recently been painted, the doors on the kitchen units were observed to be stained. An area over the cooker in the kitchen was noted to be peeling away from the surface of the kitchen unit. The inspector did not enter the residents' bedrooms in this community house as consent to enter these areas had not been provided by residents.

The second community house was noted to be in a poor state of repair and unclean. A number of rooms, including residents' bedrooms required painting. A number of areas in one of the houses required re-plastering and repair. The kitchen required repair due to areas of the kitchen doors peeling away from the surface of the door. The window blind in the kitchen was observed to be heavily stained. A number of areas in the designated centre were observed to be unclean, including the internal doors and skirting boards. Cobwebs were visible in a number of areas in the designated centre.

The designated centre had emergency lighting and a fire alarm system in place. However, the designated centre did not have fire doors in place to adequately protect escape routes in the event of a fire. It was also noted that one of the resident's bedrooms was an inner bedroom. Therefore the resident's only means of evacuation was through a kitchen. Staff spoken with told the inspector that they were waiting for funding to carry out compartmentalisation works in the designated centre. The inspector was not assured that the current fire containment and evacuation measures were sufficient to ensure the safety of residents within the centre.

The person in charge had ensured that a comprehensive assessment by an appropriate health care professional of the health, personal and social care needs of

each resident was carried out. However, the registered provider had not ensured that arrangements were in place to meet the needs of each resident. One resident had recently retired from day services and was spending the day in the designated centre. This resident was supported by staff in the designated centre until 9.30am on weekdays, with one hour of support provided by day service staff during the day. During this time, day service staff cooked the resident their dinner. A staff member came on duty on weekday evenings at 4.30pm. The inspector observed evidence that the resident had identified a number of goals they would like to achieve. These goals included having a staff support during the day and going on a day trip with the support of one staff member. The inspector spoke with the person in charge who identified that the designated centre did not have sufficient resources to support the resident in achieving these goals. This had also been identified in the designated centre's six-monthly unannounced visit. On the day of the inspection, the person in charge told the inspector that two further residents had requested to go on holiday. However, it had been identified that the designated centre did not have sufficient resources to support the residents to go on a holiday.

The inspector observed documentation from a multidisciplinary team meeting, where the person in charge had identified that they had concerns about the resident who no longer attended day service. On a visit to the designated centre, the person in charge had observed that the resident was sitting in the designated centre with no interaction and they had raised concerns regarding the impact this may have on the resident's mental health. The person in charge told the inspector that a business case for funding to support the resident during the day had been submitted; however no progress had been made since the request for funding was submitted.

The registered provider had not ensured that residents were protected from all forms of abuse. The inspector spoke with the person in charge about an allegation of abuse involving a resident living in the designated centre. The person in charge confirmed that this event had been notified to an external party for investigation. The day after the inspection, management from the designated centre contacted the inspector to inform them that the external party had not been notified. Therefore, the registered provider had not adhered to organisational policy or national standards regarding the safeguarding of vulnerable adults. The registered provider's response to adverse events that involved residents living in the designated centre, did not assure the inspector that the designated centre was effectively monitored and that the service provided to residents was safe.

The person in charge told the inspector that a business case had been submitted to request extra staffing to ensure that residents in one of the community houses were adequately safeguarded against potential abuse; however no progress had been made since the submission of the funding request. Staff spoken with on the day of the inspection raised concerns that the staffing levels in place were not sufficient to ensure that residents were adequately safeguarded. Staff members spoke about the difficulties in ensuring that one resident was supervised in line with their assessed needs and their safeguarding plan.

A comprehensive plan of care was in place for residents' health care needs. The inspector observed evidence that a resident had been supported to attend the

hospital to see the room where their procedure would take place. The resident was also supported to see the machine that would be used during the procedure, and ask staff questions about the procedure. The inspector also observed evidence that the resident was informed of their treatment options, and supported to make an informed decision about their health care.

The inspector observed staff administering medicines to residents on the morning of the inspection. It was evident that residents were supported to take their medicines in a safe and appropriate manner. A self-medication explanation form had been provided to residents, to provide them with information about medicines administration and to encourage them to administer their own medicines, in line with their wishes and capabilities. All of the staff working in the designated centre had received training in the administration of medicines.

Regulation 13: General welfare and development

The registered provider had not provided each resident with appropriate care and support, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Judgment: Not compliant

Regulation 17: Premises

The registered provider had not ensured that the designated centre was kept in a good state of repair externally and internally, clean and suitably decorated.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had ensured that there were systems in place for the assessment, management and ongoing review of risk.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had not made adequate arrangements for containing fires and evacuating all person in the designated centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured that the designated centre had appropriate and suitable practices relating to the administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessment by an appropriate health care professional of the health, personal and social care needs of each resident was carried out. However, the registered provider had not ensured that arrangements were in place to meet the needs of each resident.

Judgment: Not compliant

Regulation 6: Health care

The registered provider ensured that appropriate health care was provided for each resident, having regard to the individual residents' personal plan.

Judgment: Compliant

Regulation 8: Protection

The registered provider had not ensured that residents were protected from all forms of abuse.

Judgment: Not compliant

Regulation 9: Residents' rights
The registered provider had not ensured that each resident, in accordance with his or her wishes, had the freedom to exercise choice and control in their daily life.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kingfisher 1 OSV-0004836

Inspection ID: MON-0023389

Date of inspection: 09/10/2019

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Registered Provider shall ensure compliance with regulation. In this regard the following is taking place:- o Continue engagement with funder regarding business cases pertaining to two of residents in the designated centre. o A Business Case has been completed for one individual and submitted to the funder on September 5th 2019. This was last discussed and prioritized at business case meeting with the funder on 11/11/2019. The funder has confirmed that this business case has been included on the agenda of a meeting with the Chief Officer on 25/11/2019. o A Business case for an individual in the second house was submitted to the funder originally in 16th November 2018. This was last discussed and prioritized at business case meeting with the funder on 11/11/2019. The funder has confirmed that this business case has been included on the agenda of a meeting with the Chief Officer on 25/11/2019. o The funder confirmed by email on 29th November 2019 that the outcome of the meeting was that while the funder would like to be in a position to have the available resources to fund these business case requests, the resources are not available at this time. o The Services does not have additional resources to allocate to this designated centre from within its existing resources. It will continue to make every efforts to address the needs of residents from within the current funded staffing levels. o Copy of forensic report was given to the funder at the business case meeting on 11/11/2019 in order to further strengthen this business case originally submitted on 16th November 2018. o The funder visited the designated centre 30/10/2019 to review decision of provider not to fill vacant bed. Both PPIMs were present for this visit to ensure representatives of the funder were fully briefed in terms of the needs of the residents in the designated centre. The Provider awaits the outcome of this visit. o Business case meetings are scheduled on a monthly basis with the funder to ensure ongoing issues, as they arise, are highlighted to the funder in terms of the requirement for additional staffing.	

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

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 shall ensure compliance with this regulation. In this regard the following is taking place:-

o The Designated Officer will ensure that following each allegation of abuse that a template will be returned to the Person in Charge that sets out the outcome of the Preliminary Screening. This template has been completed by the designated officer.

o The Designated Officer used the HSE Safeguarding reporting document (Preliminary Screening Outcome Sheet PSF2) as a basis for this template.

o On receipt of this template the Person in Charge will attach a copy of this sheet to the copy of the CP1 and retain this securely in a separate file accessible only by the Person in Charge and PPIM. This can be presented to the Inspector in respect of any query in relation to safeguarding concerns.

o This system has been rolled out to all Persons in Charge following briefing of the new template at the Director of Services/PIC meeting on 30th October 2019.

o The Complaints Officer will ensure that in future any communication between themselves and the Complainant will be shared with the Person in Charge and PPIM.

o The Complaints Officer will review all formal complaints for the past 2 years to ensure that Persons in Charge have been updated as to the status of formal complaints. The results of the review will be reported formally to the Director of Services.

o The Director of Services will ensure that any communication between themselves and the Complainant will be shared with the Person in Charge and PPIM.

o The Director of Services will review all formal complaints for the past 2 years to ensure that Persons in Charge and PPIM have been updated as to the status of formal complaints. The results of the Review will be communicated formally to the Chief Executive.

o PIC will review informal complaints log to ensure that the complaints have been closed or if not have been escalated. Where they have been escalated the PIC will confirm that they are aware of the outcome of the formal complaints process.

o This learning in respect of this inspection has been shared with the Persons in Charge at the monthly meeting that took place on 30th October 2019 and Persons in Charge has been instructed to ensure that all informal complaints are followed up to make they are either closed or escalated.

o The Designated Officer together with another Designated Officer from another BOCSI region will carry out a review of designated files in order to satisfy themselves that the allegations of abuse that are of a criminal nature have been reported to the Gardai as per the Organisations Policy and Procedures on Safeguarding. The period of this audit will be from the Introduction of the HSE Policy on Safeguarding in 2015.

o A report will be issued by Audit team following the audit to the Director of Services

with recommendations
o Any cases identified during the course of the audit that were not reported to the Gardai but are now deemed to be reportable will be reported immediately to the Gardai.
o Recommendations and learnings from this audit will be shared with the National Designated Officer group.
o Director of Services met with Complaints Officer on 14th October 2019 and agreed that a meeting between the Complaints Officer and the Director of Services will take place, after each formal complaint process, where the complaint is not resolved to agree a process for escalation outside of the organisation.

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

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The Registered Provider shall ensure compliance with this regulation. In this regard the following is taking place:-

o The Complaints Officer will ensure that any communication between themselves and the Complainant will be shared with the Person in Charge and PPIM.
o The Complaints Officer will review all formal complaints for the past 2 years to ensure that Persons in Charge have been updated as to the status of formal complaints and formally write to the Director of Services with regards to the outcome.
o The Director of Services will ensure that any communication between themselves and the Complainant will be shared with the Person in Charge and PPIM.
o The Director of Services will review all formal complaints for the past 2 years to ensure that Persons in Charge and PPIM have been updated as to the status of formal complaints and will formally write to the Chief Executive to advise as to the outcome of this review.
o PIC will review informal complaints log to ensure that the complaints have been closed or if not have been escalated. Where they have been escalated the PIC will confirm that they are aware of the outcome of the formal complaints process.
o This learning was shared with the Persons in Charge at the monthly meeting that took place on 30th October 2019. Persons in Charge were directed to review informal complaints to make sure that they are either closed or escalated.
o Following learning from this review a guidance has been issued to all PICs to advise where support is being provided by the PIC to escalate a complaint to formal that a clear indication in the subject line in the email to the complaints officer is set out. This was also discussed at the PIC meeting with the Director of Services on 30th October 2019.
o Director of Services has met with Complaints Officer on 14th October and agreed that a meeting between the Complaints Officer and the Director of Services, after each formal complaint process, where the complaint is not resolved to agree a process for escalation outside of the organisation.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

• The Registered Provider shall ensure compliance with regulation. In this regard the following is taking place:-

o Continue engagement with funder regarding business cases pertaining to two of residents in the designated centre that will ensure that all residents are in receipt of support in line with this regulation.

o A Business Case has been completed for one individual and submitted to the funder on September 5th 2019. This was last discussed and prioritized at business case meeting with the funder on 11/11/2019. The funder has confirmed that this business case has been included on the agenda of a meeting with the Chief Officer on 25/11/2019.

o A Business case for an individual in the second house was submitted to the funder originally in 16th November 2018. This was last discussed and prioritized at business case meeting with the funder on 11/11/2019. The funder has confirmed that this business case has been included on the agenda of a meeting with the Chief Officer on 25/11/2019.

o The funder confirmed by email on 29th November 2019 that the outcome of the meeting was that while the funder would like to be in a position to have the available resources to fund these business case requests, the resources are not available at this time.

o The Services does not have additional resources to allocate to this designated centre from within its existing resources. It will continue to make every efforts to address the needs of residents from within the current funded staffing levels and manage the risks as per the risk assessment.

o Copy of forensic report was given to the funder at the business case meeting on 11/11/2019 in order to further strengthen this business case originally submitted on 16th November 2018.

o The funder visited the designated centre 30/10/2019 to review decision of provider not to fill vacant bed. Both PPIMs were present for this visit to ensure representatives of the funder were fully briefed in terms of the needs of the residents in the designated centre. The Provider awaits the outcome of this visit.

o Business case meetings are scheduled on a monthly basis with the funder to ensure ongoing issues, as they arise, are highlighted to the funder in terms of the requirement for additional staffing.

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

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Registered Provider shall ensure compliance with regulation. In this regard the following is taking place:-

• A deep clean of one house in the designated centre has been arranged and will be completed by 29th November 2019.
• Painting of one house has been approved and will be completed by 31st January 2019.
• Exit door in internal bedroom will be installed as a priority in apartment in advance of other fire works commencing. The fire safety engineer has commenced reviewing the apartment in order to develop a specification for the door to be installed. Challenges to installing a door have been identified so it will take time to address. It is anticipated that this will be resolved by 31st March 2020.
• The window blind will be replaced in the kitchen of one house.
• Upgrade of kitchen in one house has been approved and will be completed by 31st March 2020. The second kitchen will be prioritized for upgrade in quarter 2 of 2020.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Registered Provider shall ensure compliance with regulation. In this regard the following is taking place:-
• The HSE has appointed a fire safety consultant firm to carry out fire safety reviews. This process has commenced. Dates for the review of this designated centre has not yet been agreed. This important matter is being followed up nationally by the Chief Executive.
• Exit door will be installed in internal bedroom in advance of the fire safety audit. The fire safety engineer has commenced reviewing the apartment in order to develop a specification for the door to be installed. Challenges to installing a door have been identified so it will take time to address. It is anticipated that this door will be installed by 31st March 2020.

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 Registered Provider shall ensure compliance with regulation. In this regard the following is taking place:- o Continue engagement with funder regarding business cases pertaining to two of residents in the designated centre. o A Business Case has been completed for one individual and submitted to the funder on September 5th 2019. This was last discussed and prioritized at business case meeting with the funder on 11/11/2019. The funder has confirmed that this business case has been included on the agenda of a meeting with the Chief Officer on 25/11/2019. o A Business case for an individual in the second house was submitted to the funder originally in 16th November 2018. This was last discussed and prioritized at business case meeting with the funder on 11/11/2019. The funder has confirmed that this business case has been included on the agenda of a meeting with the Chief Officer on 25/11/2019. o Copy of forensic report was given to the funder at the business case meeting on 11/11/2019 in order to further strengthen this business case originally submitted on 16th November 2018. o The funder confirmed by email on 29th November 2019 that the outcome of the meeting was that while the funder would like to be in a position to have the available resources to fund these business case requests, the resources are not available at this time. o The Services does not have additional resources to allocate to this designated centre from within its existing resources. It will continue to make every efforts to address the goals of residents from within the current funded staffing levels. o A voluntary organisation will be contacted with the view to exploring the achievement of the goal identified in respect of going on a foreign holiday. o The funder visited the designated centre 30/10/2019 to review decision of provider not to fill vacant bed. Both PPIMs were present for this visit to ensure representatives of the funder were fully briefed in terms of the needs of the residents in the designated centre. The Provider awaits the outcome of this visit. o Business case meetings are scheduled on a monthly basis with the funder to ensure ongoing issues, as they arise, are highlighted to the funder in terms of the requirement for additional staffing. o Risks pertaining to this designated centre are reviewed on a quarterly basis. The risk register is up to date as confirmed at the last 6 month unannounced inspection. The next risk assessment review is to be completed by 30th November 2019 in line with procedures. **The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.**	

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Registered Provider shall ensure compliance with regulation. In this regard the following is taking place:-

o The Designated officer has provided assurances that all such matters, where reasonable grounds are established, will be immediately reported to an Garda Siochana going forward as per normal practice.
o The designated officer will ensure that the Gardai are contacted where grounds are established.
o The Designated Officer has contacted the Gardai informally on 10/10/2019 to advise them of this allegation. The incident was formally reported to the Gardaí on 15th October 2019. The Designated Officer has confirmed this in writing to the Director of Services.
o The Designated Officer spoke with the family member of the Person who was the alleged victim to update the family of the recent developments with regards to the HIQA inspection and the fact that the allegation was now being reported to the Gardai
o Designated Officer confirmed in writing to the Director of Services on the 21st October that they had contacted the family of the alleged victim to advise them that the allegation of abuse by a peer had now been reported to the Gardai.
o The Director of Services, on 22nd October 2019, wrote formally to the family confirming the situation and invited the family to meet with her in order to raise any concerns that they may have with regards to the services being provided to their sibling.
o A template has been developed for management and monitoring group, which supports the designated officer, to ensure that all necessary stakeholders are informed of an allegation of abuse.
o This action will be on the agenda for the next Management and Monitoring group scheduled for 7th November 2019. This meeting did not take place due to the Designated Officer being on sick leave. This meeting will be rescheduled.
o Request has been made by the Designated Officer to meet with the HSE Safeguarding team to review this finding. Any further learnings or additional control measures identified will be implemented.
o The Designated Officer will ensure that following each allegation of abuse that a template will be returned to the Person in Charge that sets out the outcome of the Preliminary Screening. This template has been developed by the Designated Officer.
o The Designated Officer used the HSE Safeguarding reporting document (Preliminary Screening Outcome Sheet PSF2) as the basis for this template.
o On receipt of this template the Person in Charge will attach a copy of this sheet to the copy of the CP1 and retain this securely in a separate file accessible only by the Person in Charge and PPIM. This can be presented to the Inspector in respect of any query in relation to safeguarding concerns.
o This system has been presented by the Designated Officer at the Director of Services/PIC meeting on 30th October 2019.
o The Designated Officer together with another Designated Officer from another BOCSI region will carry out a review of designated files in order to satisfy themselves that the allegations of abuse that are of a criminal nature have been reported to the Gardai as per the Organisations Policy and Procedures on Safeguarding. The period of this audit will be from the Introduction of the HSE Policy on Safeguarding. The revised date for

completion of this audit is 31st December 2019.
o A report will be issued following the audit to the Director of Services with recommendations
o Any cases identified during the course of the audit that were not reported to the Gardai but are now deemed to be reportable will be reported immediately to the Gardai.
o Recommendations and learnings from this audit will be shared with the National Designated Officer group.
o The business case has been prioritized for funding and will be discussed with the Chief Officer on 25th November 2019. Forensic report has been submitted to the Funder by way of supporting documentation. This business case was originally submitted to the HSE on 16th November 2018.
o The funder confirmed by email on 29th November 2019 that the outcome of the meeting was that while the funder would like to be in a position to have the available resources to fund this business case request, the resources are not available at this time.
o The Services does not have additional resources to allocate to this designated centre from within its existing resources. It will continue to make every effort to address the needs of the residents from within the current funded staffing levels and manage the risks as per the risk assessment.
o MDT have had an initial meeting to review the recommendations of the forensic report. Recommendations that are within the services control will be acted on as a priority including the review of restrictive practices and the engagement of a male psychologist in providing relationship and sexuality training to the person causing concern.

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

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
o The Registered Provider shall ensure compliance with regulation. In this regard the following is taking place:-

o The risk assessment which is in place to support the individual to remain in their home during the day, which is their choice, will continue to be monitored closely by the PIC in order to ensure that the safety of the resident is managed while ensure the resident exercises her choice.
o The business cases for this designated centre, submitted to the HSE and prioritized for funding, will ensure that residents in both houses are enabled to exercise choice and control in their daily life. Meeting with the Chief Officer is taking place on 25th November 2019 to review these business case.
o In the event that the business case is approved additional staff will be assigned to the designated centre and will further support the rights of residents.
o The funder confirmed by email on 29th November 2019 that the outcome of the meeting was that while the funder would like to be in a position to have the available resources to fund these business case requests, the resources are not available at this time.

o The Services does not have additional resources to allocate to this designated centre from within its existing resources. It will continue to make every effort to address the needs of residents from within the current funded staffing levels and manage the risks as per the risk assessment.
o The funder has instructed that services must operate within its allocation and only life or limb risks would be considered. At the last PIC meeting on 30th October the Head of Community Services advised that business case in respect of quality of life would now be submitted to the funder in order to demonstrate our commitment in supporting individuals to have a good life.

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

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/01/2020
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	31/01/2020
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Not Compliant	Orange	31/01/2020

	accordance with their interests, capacities and developmental needs.			
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/01/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	28/02/2020
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'	Not Compliant	Orange	31/12/2019

	needs, consistent and effectively monitored.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2020
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	Orange	31/12/2020
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	30/10/2019
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	30/10/2019
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	31/01/2020

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/01/2020
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/12/2019
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	31/01/2020
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/01/2020