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:	Rosenheim Services
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	17 and 18 October 2019
Centre ID:	OSV-0005330
Fieldwork ID:	MON-0023036

About the designated centre

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

The designated centre is run by the Health Service Executive (HSE) and is located outside a town in Co. Sligo. The centre consists of five residential houses which are in close proximity to each other. The centre provides residential services to people with an intellectual disability, who have been identified as requiring low to high levels of support. The service can accommodate male and female residents, from the age of 18 upwards. Three of the houses provide accommodation for four residents, one of the houses provides accommodation for three residents and one of the houses provides accommodation for five residents. All houses are two-storey dwellings and have a communal kitchen and dining area, sitting-room, bathroom facilities and single and shared bedrooms. Transport arrangements are in place to access community-based activities and include shared transport between the five houses, public buses and taxis. The houses are staffed with a mix of nursing staff and health care assistants, with night duty cover arrangements in two houses and sleepover arrangements in three houses each night. There was a nurse available to assist with care between the hours of 18.30 and 00.00 and also provide cover between three designated centres in the area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19

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
17 October 2019	11:45hrs to 20:30hrs	Angela McCormack	Lead
18 October 2019	10:10hrs to 16:30hrs	Angela McCormack	Lead
17 October 2019	11:45hrs to 20:30hrs	Thelma O'Neill	Support
18 October 2019	10:10hrs to 16:30hrs	Thelma O'Neill	Support

Views of people who use the service

During the course of the inspection, inspectors got the opportunity to meet with eighteen residents who lived at the centre. Inspectors found that residents had different experiences of care and support depending on which house they resided in the centre.

Some residents who inspectors spent time with stated that they were happy in the centre and spoke about a range of activities that they enjoyed in the community. This included being involved with guest lecturing at the local college, being members of a local committee, fund raising for a community defibrillator, horse riding, swimming, attending shows and being involved in sports clubs. During the inspection, inspectors observed residents engaging in leisure activities in the house, completing household tasks and accessing a sports club in the local community. One resident who spoke with inspectors said they were happy to get the chance to meet with inspectors on this occasion, and said that they were happy that the inspectors had come on this particular day as they were busy with activities on other evenings during the week. On the second day of inspection,residents told the inspectors about the activities they enjoyed which included going to football games, going to the gym and attending music festivals.

However, in other parts of the centre residents who inspectors spoke with expressed dissatisfaction about aspects of their care, including meal choices and access to treats; with one resident saying that they liked to go home to their family as they could then choose what they ate. In addition, two residents in one house did not have access to an formal day service and did not appear to have access to an alternative meaningful day programme.With inspectors observing them only engaged in knitting in their bedroom and watching television during the course of the inspection.

Throughout the course of the inspection, residents were observed to have positive and caring friendships with each other. Staff who were supporting residents throughout the inspection appeared knowledgeable about residents' needs, and were observed to be supporting residents in a respectful and dignified manner.

Capacity and capability

Inspectors found that the governance and management arrangements in place at Rosenheim Services was poor, which was negatively impacting on the quality of life and safety of residents in two of the houses in the centre. The inspectors found a number of risks on the first day of inspection, which were brought to the attention of the person in charge. This included the safeguarding of residents, staffing

arrangements, risk management, fire safety and the suitability of the centre's premises.

Over the course of the inspection the provider did not demonstrate that it had robust governance and management arrangements in place to ensure a consistent approach to meeting residents' needs and in providing a safe and effective service to all residents. The provider had regularly completed the six monthly unannounced audits of the centre, and had identified themselves that this centre required an additional quality assurance assessment. While this review had been completed on 1st October, 2019; the subsequent quality improvement plan did not capture some of the high risks that inspectors found on inspection. For example; risk of harm to residents, safeguarding concerns, fire evacuation and some risks relating to the premises.

The person in charge was responsible for one other designated centre in the local area in addition to the five houses within Rosenheim Services. Inspectors found the person in charge to be suitably qualified, experienced and knowledgeable about residents' needs. While the person in charge had auditing systems in place, these audits did not identify high risk concerns and ensure that they were appropriately managed and identified on the centre's risk register. For example, a resident who had mobility needs which had resulted in falls and bruising, and was unable to independently access their bedroom as it was located upstairs was not identified on the risk register.

Inspectors found that residents' rights were not promoted at all times in some parts of the centre. Some institutional practices were found on inspection, which impacted on residents' quality of life and right to make choices in their day to day lives. For example, some residents in one house were denied choices of food.

Furthermore, inspectors spoke with residents and completed a review of residents' care notes, which highlighted that concerns raised by residents about the care they received at the centre had not been escalated by staff or investigated by the provider. In addition, as the recorded complaints related to staff treatment of residents, inspectors found that the person in charge or provider had not initiated procedures in line with their organisational safeguarding policy or notified the Chief Inspector in line with the regulations.

Inspectors reviewed the staffing arrangements in the centre and found that these did not consistently meet the assessed needs of residents. There was a large reliance on agency staff in some houses. Inspectors found that in two houses within the centre, only one staff member was rostered to provide support to four residents in each house, some of whom had complex health needs. This resulted in residents having limited opportunity for one-to-one community activities, with the majority of activities being group-based, and on some occasions staff shortages resulted in activities being cancelled. The person in charge further confirmed to inspectors that there were six staff vacancies in the centre currently, and staff told inspectors that additional staffing was required to meet residents' needs. In order to provide increased opportunities for residents to access community activities, inspectors noted that the provider had allocated an additional staff post to support residents

across the centre's five houses. However, inspectors found that this staffing resource was frequently being used to cover staff absences at the centre, and had not always lead to increased opportunities for residents, which was confirmed by the person in charge during the inspection.

Regulation 14: Persons in charge

The person in charge had the appropriate qualifications and experience to manage the centre. While the inspectors found that she was knowledgeable about the individual needs of residents; she did not demonstrate that there were effective systems in place to ensure an appropriate level of oversight which would ensure that a quality and safe service was delivered to residents at all times.

Judgment: Not compliant

Regulation 15: Staffing

Inspectors found that there were insufficient staff in place to meet the needs of residents in some parts of the designated centre. In addition, hours that were assigned for social outings were at times utilised to cover staff absences, which resulted in a reduction of residents' accessing community outings of choice.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were provided with mandatory and refresher training as part of their continuous professional development. The person in charge maintained a schedule for staff supervision meetings, and had carried out a number of staff supervision meetings at the time of inspection, with further dates set.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre did not ensure that residents' needs were met at all times, and that safe services were provided consistently to residents. The oversight arrangements were not effective in ensuring

that high risk issues and concerns of a safeguarding nature were identified and managed appropriately.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that all notifications had been submitted to the Chief Inspector of Social Services as required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a system in place for responding to complaints and an easy-to-read version was on display in the centre. However, inspectors found that the complaints procedure was not consistently followed.

Judgment: Substantially compliant

Quality and safety

The inspectors found that significant improvements were required in the centre to ensure that the care delivered to residents was safe, of a high quality and in line with residents' needs and individual choices.

Inspectors found that residents' rights were not promoted at all times in some parts of the centre. Although staff had received training in safeguarding, concerns raised by residents regarding denial of food choices and alleged staff behaviour had not been identified as potential safeguarding concerns. For example, it was noted in care notes that a resident expressed that they felt like they were 'treated like a baby' and did not like the way certain staff treated them. Residents told inspectors that they were not permitted treats when certain staff were on duty, with one resident telling an inspector that they liked to go home to family as they could choose what they wanted to eat at home. In addition, there was disrespectful language used in some care notes with regard to residents' intimate care management, and this had not been identified and addressed by the person in charge. The person in charge acknowledged that she was not aware of these concerns, and safeguarding procedures had not been followed to establish if there were reasonable grounds for concern. In addition, where a concern had been raised

by a resident in another part of the centre about the way a staff had spoken to them, while this was dealt with through the complaints procedure, a safeguarding preliminary screening had not been completed in line with the provider's safeguarding policy.

Residents' rights to privacy were not maintained in some parts of the centre. Six residents shared bedrooms in three of the centre's houses. Although residents told inspectors they were happy with sharing bedrooms and privacy screens were in place, inspectors observed that the shared rooms were small in size and residents had limited space for private time alone. This resulted in two residents who shared a bedroom having an agreed arrangement in place which allowed each of them to have time in the bedroom alone. In addition, in one house inspectors noted that due to lack of space in their bedroom, one resident's wardrobe was located in the communal laundry/ utility room. Furthermore, inspectors found that some of the houses within the centre were in need of both internal and external painting.

Inspectors found that residents were not adequately protected from harm in some parts of the centre. An assessment of the houses' fire evacuation plans had not been completed to ensure their effectiveness under all circumstances. For example, the provider had not ensured that a fire drill was completed under minimum staffing arrangements. In addition, inspectors found in incidences where residents had refused to evacuate during a nine month period that appropriate measures had not been put in place to address this issue. Furthermore, one resident at the centre due to their assessed mobility needs, could not evacuate independently from their upstairs bedroom and inspectors were told that in the event of a fire the resident could be left in the bedroom until emergency services arrived. However, this risk had not been identified on the service's risk register or evacuation plan.

The centre's premises were all two-storey properties. The design and layout of one house within the centre did not meet the assessed needs of a resident with mobility needs. Due to their mobility, the resident required one-to-one support at all times to access their upstairs bedroom, which resulted in regular incidents of bruising from support required on the narrow stairway. This impacted on their personal choice and quality of life at the centre, with the resident telling inspectors that they could not access the stairs on their own as it was too dangerous.

In general, inspectors found that residents' health, personal and social care needs were assessed and care plans were developed where required. In addition, where residents required additional support with behaviours of concern, clear plans were put in place which guided staff practice and provided information about proactive and reactive support strategies. However, in some incidences inspectors found that some aspects of health care needs were not appropriately assessed, and guidance put in place to ensure staff could effectively meet their needs. Some residents who the inspectors spoke with talked about the various activities that they engaged in, their involvement in their annual review meetings and some of their goals for the future. However, inspectors found that a resident who had recently been suspended from attending their day service had not been provided with an alternative day programme at the centre. The lack of an alternative day programme meant that the resident remained at home with little opportunity to participate in activities which

reflected their assessed needs, interests and abilities.

Regulation 13: General welfare and development

The inspector found that a resident who had recently been suspended from attending their day service due to a safeguarding concern had not had the issue resolved, which meant that the resident continued to remain at home with little opportunity to participate in activities in line with their interests and capacities.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors found that the centre required improvements to ensure that it met the numbers and needs of residents, that it was in a good state of repair and that all the requirements of Schedule 6 in the regulations were in place.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was a high level of risk in the designated centre and the provider did not demonstrate that this was being managed effectively. For example, risks in relation to residents bruising, falls, residents' changing needs, fire evacuation, premises, staffing levels and residents' right to privacy and dignity had not been adequately assessed and managed. In addition, some residents' individual risk assessments and the service's risk register were not reflective of the actual risks posed.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had ensured that there were fire safety management systems in place in the centre including fire doors, emergency lights, smoke and heat sensors and fire fighting equipment. Regular fire drills were conducted by staff; however, the fire drills did not demonstrate that all residents could be safely evacuated from the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors found that in general residents' health, personal and social care needs were assessed. Residents had personal plans in place and were supported to identify and achieve meaningful goals in line with their wishes. However, inspectors found that there were some incidences where residents' health needs were not clearly identified and assessed.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that residents who required support with behaviours of concern had plans in place to support them, which were reviewed regularly and had a multidisciplinary input.

Judgment: Compliant

Regulation 8: Protection

Staff had received training in safeguarding and a review of residents' meetings demonstrated that residents had been supported to understand how to stay safe. However, the inspectors found that some concerns raised by residents had not been identified as being possible safeguarding concerns, and therefore safeguarding procedures had not been followed to ensure residents' safety.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors found that in some cases residents' rights had not been consistently respected with regard to the residents' freedom to make choices and have control in their daily life. The lack of availability of staff in some parts of the centre resulted in limited choices about community access.

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	Not 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	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Rosenheim Services OSV-0005330

Inspection ID: MON-0023036

Date of inspection: 17/10/2019 and 18/10/2019

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 Provider has reviewed Rosenheim Services in the context the number of houses which make up the designated centres and the overall governance structure across both Sligo/Leitrim Disability Services and CHO1.

As a result of this review, the provider will make application to the authority to reduce the number of houses under this designated centre as follows:
• An application will be submitted for a variance of the existing designated centre to reduce the centre to 2 houses.
• A second application to register will be submitted for the 3 remaining houses as a new designated centre.
• A second PIC has been identified for this change and an application will also be submitted in relation to their appointment.

Pending submission and approval of the above proposed changes
• A Clinical Nurse Manager 2 is providing additional support to the existing PIC for this centre to ensure the required oversight
• The Director of Nursing has commenced weekly review meetings with the PIC, CNM2 and the staff team supporting this centre as of 21/10/2019. The focus of these meetings is progress on the actions to address areas of non-compliance identified by HIQA Inspection and Self-Assessment. Any direction or support which requires Disability Management approval will be escalated by the Director of Nursing.
• The Director of Nursing has commenced weekly onsite visits to provide support and supervision for the PIC and the frontline staff team.
• Director of Nursing completed a retrospective safeguarding and risk look back review from January 2019 until present day within the centre to identify any potential safeguarding concerns not previously recognised as same.
• Screening of any potential safeguarding concerns was undertaken and safeguarding plans were put in place as required in consultation with the Safeguarding and Protection

Team
• Learning from the retrospective safeguarding and risk look back review has been disseminated to both staff team within Rosenheim Services and within the wider Sligo/Leitrim Disability Services

The impact of proposed changes to the designated centre as experienced by the residents will be a new agenda item for the weekly residents meetings. The Director of Nursing and Disability Management will seek feedback from the PIC on this and take cognisance of same during this transition.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The staffing for Rosenheim Services has been reviewed and the following immediate changes have been implemented across the designated centre:
• An additional Clinical Nurse Manager 2 has commenced on site support in the centre – commenced 18/11/2019.
• Staffing across the designated centre has been reviewed and the following has been put in place:
o The sleepover roster in house 137 has been replaced by a waking roster including an additional 1 WTE support as of 06/11/2019.
o An additional 1 WTE has been assigned to house 137 to allow for 24 hour support in each house independently as of 04/11/2019.
The impact of the above staffing changes, is to make available social support hours to ensure residents have the opportunity to participate in activities in line with their wishes.

The night duty roster will be reviewed in the remaining 3 houses under this designated centre to be completed by the 06/12/2019.

A process of agency conversion to full time HSE staff positions has been commenced for 4 agency staff currently working across this centre. This will be completed by 16/12/2019.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider has reviewed Rosenheim Services in the context the number of houses

which make up this designated centre and the overall governance structure across Sligo/Leitrim Disability Services.

To strengthen the existing management structure, the provider will make application to the authority to reduce the number of houses under this designated centre as outlined previously.

Pending submission and approval of the above proposed changes
• A Clinical Nurse Manager 2 is providing additional support to the existing PIC for this centre to ensure the required oversight
• The Director of Nursing has commenced weekly review meetings with the PIC, CNM2 and the staff team supporting this centre as of 21/10/2019. The focus of these meetings is progress on the actions to address areas of non-compliance identified by HIQA Inspection and Self-Assessment. Any direction or support which requires Disability Management approval will be escalated by the Director of Nursing.
• The Director of Nursing has commenced weekly onsite visits to provide support and supervision for the PIC and the frontline staff team.
• Director of Nursing completed a retrospective safeguarding and risk look back review from January 2019 until present day within the centre to identify any potential safeguarding concerns not previously recognised as same.
• Screening of any potential safeguarding concerns was undertaken and safeguarding plans were put in place as required in consultation with the Safeguarding and Protection Team
• Learning from the retrospective safeguarding and risk look back review has been disseminated to both staff team within Rosenheim Services and within the wider Sligo/Leitrim Disability Services

Additional to the existing regulatory requirements of unannounced visits, the Provider Nominee and Regional Director of Nursing will conduct 4 unannounced site visits prior to March 2020.

Oversight of the Quality Improvement Plan for this centre will continue on a weekly basis by the Office of the General Manager.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Director of Nursing has re-issued a direction to all staff in relation to their requirement to notify the relevant agency (HIQA, Safeguarding and Protection Team) when an incident or allegation suspected or confirmed of abuse of any resident occurs.

A retrospective safeguarding and risk look back review from January 2019 until present day has been completed and any retrospective reporting to the authority has been

completed and required notifications submitted as of 31/10/2019.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Director of Nursing has commenced a retrospective review of resident's notes, minutes of resident's meeting and other documents from January 2019 to current to ensure that to ensure that any concerns or complaints identified are addressed and managed effectively. All such complaints will be investigated in line with HSE Complaints policy.
To ensure appropriate identification and management of complaints on an on-going basis, the following will be undertaken:
• The nominated complaints person will ensure that records maintained include details of any investigation and the complainants' satisfaction with the outcome.
• All staff will complete complaints awareness training schedule for 30/11/2019.

The complaints officer has review all complaints to date and verified that same have been addressed and the necessary follow up completed in accordance with the HSE's Complaints Policy.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Staffing across the designated centre has been reviewed and the following has been put in place:
o The sleepover roster in house 137 has been replaced by a waking roster including an additional 1 WTE support as of 06/11/2019.
o An additional 1 WTE has been assigned to house 137 to allow for 24 hour support in each house independently as of 04/11/2019.
The impact of the above staffing changes, is to make available social support hours to ensure residents have the opportunity to participate in activities in line with their wishes.

In relation to one resident suspended from their day service:
• A meeting held on the 11/11/2019 with day service provider to plan the reintroduction of a resident back to day services.
• The Clinical Nurse Specialist, Behaviors of Concern and Clinical Nurse Specialist,

Community Living are working with this resident and the day service provider to develop a transition plan – first meeting scheduled for week beginning 18/11/2019.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A full review of the 5 premises under this designated centre has been undertaken. To ensure that the premises are in a good state of repair the following will be undertaken:
• Internal painting and decorating in House 44 - completed 06/11/2019.
• Internal painting and decorate of the apartment adjacent to House 16 –to be completed by 31/12/2019.
• Replace Patio doors in House 207 - to be completed 31/01/2020.
• External painting of House 136, House 137, House 44, House 207 and House 16 – to be completed by 31/03/2020
• Resurfacing works to driveways of House 136, House 137, House 44 and House 16 - to be completed by 31/12/2019.

The following improvements will be carried out across the designated centre to ensure that the needs of residents are met in line with their assessed needs and respecting their right to privacy:
• A downstairs bedroom will be developed from the office space in House 136. This will be completed by 31/03/2020. This will provide one person with an individual bedroom suitable to mobility needs.
• An additional bedroom has been made available in House 137 to eliminate the shared bedroom arrangement in that house as of 11/11/2019 due to the change in staffing roster.
• 1 resident in house 207 to relocate to another designated centre. This will facilitate individual bedrooms for all residents in this house. To be completed by 30/03/2020.
• Restructure to staffing roster in House 16 will take place to facilitate residents to have their own bedrooms. This will be completed by 06/12/2019.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk Management within the centre has been strengthened. A full examination of Health, Safety and Risk Management within Rosenheim Services has been undertaken –

completed 08/11/2019.

In addition, individual risks will be reviewed, existing controls measures will be evaluated and where these are not effective in managing the risk, additional controls will be identified and implemented – to be completed by 18/11/2019.

To ensure appropriate identification and management of risk on an on-going basis, the following will be undertaken:
• Risk training has been scheduled for all staff within the designated centre on the 18/11/2019.
• Incident Review Group will review escalation form for referrals from designated centre to service risk register. To be completed by 30/11/2019.
• Staffing across the designated centre has been reviewed and additional supports are in place as of 06/11/2019.

To mitigate specific risks identified by HIQA in the inspection the following actions will be undertaken:
• One resident will move to a downstairs bedroom facility by 31/03/2020. This will minimise the risk of bruising, falls and risks associated with fire evacuation for this resident.
• Speech and Language Therapist will review individual mealtime guidelines with the support of the CNS and Staff Nurses across the centre. This was completed by 08/11/2019.
• All staff within the centre will receive International Dysphagia Diet Standardisation Initiative training on mealtimes. This is scheduled to be completed by 31/12/2019.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Sligo Fire Services Fire Officer and Fire Prevention Officer have carried out a comprehensive onsite inspection on the 30/10/2019 to review all fire safety management systems. A full report will be provided to HSE Disability Services – to be provided by 29/11/2019.

Pending receipt of same:
• Information in relation to residents within this designated centre was forwarded to the Fire Officer to update the fire risk card for this designated centre on 18/10/2019.
• A fire evacuation with maximum number of residents and minimum number of staffing was undertaken in each house across this designated centre - completed 10/11/2019.
• All personal emergency evacuation plans and Fire Orders have been updated as per fire evacuations procedures conducted by staff. Specific advice was sought and received from the Fire Officer with regard to a resident that has previously refused to evacuate. A new personal emergency evacuation plan has been developed to reflect advice received - 10/11/2019.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• Each resident's assessment of needs and individual risks has been reviewed, updated to reflect the additional supports required to minimise risks and provide a safe environment – complete 01/11/2019
• Each resident's annual health review has been completed - 17/10/2019
• Each resident's annual review has been scheduled and will be completed by 31/12/2019. Multi-disciplinary team input will form part of this review.
• Speech and Language Therapist has reviewed individual mealtime guidelines with the support of the CNS and Staff Nurses across the centre – complete 08/11/2019.
• Food diaries have now been introduced for all residents - commenced 30/10/2019.
• In relation to one resident suspended from their day service, the Clinical Nurse Specialist, Behaviors of Concern and Clinical Nurse Specialist, Community Living are working with this resident and the day service provider to develop a transition plan – first meeting scheduled for week beginning 18/11/2019.
• Staffing across the designated centre has been reviewed and the impact of the additional staffing the following has been put in place is to make available social support hours to ensure residents have the opportunity to participate in activities in line with their wishes.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In acknowledgement of the issues raised by the Inspectorate as potential safeguarding concerns the following actions were taken:

• Director of Nursing completed a retrospective safeguarding and risk look back review from January 2019 until present day within the centre to identify any potential safeguarding concerns not previously recognised as same.
• Screening of any potential safeguarding concerns was undertaken and safeguarding plans were put in place as required in consultation with the Safeguarding and Protection Team.
• Retrospective reporting to the authority has been completed and required notifications submitted. This was completed by the 31/10/2019.
• The full documentation on active safeguarding investigations is now located within the

centre.

To ensure appropriate identification and reporting of potential safeguarding concerns on an ongoing basis:
• Learning from the retrospective safeguarding and risk look back review has been disseminated to both staff team within Rosenheim Services and within the wider Sligo/Leitrim Disability Services
• The requirement to discuss safeguarding or potential concerns within the centre at staff and residents meetings was re-affirmed by the Director of Nursing to the person in charge and all centre staff.
• Refresher training on Safeguarding and Protection for all staff within Rosenheim Centre is scheduled to be completed by 12/12/2019.
• The location of existing accessible format information on Safeguarding will be examined to ensure that this is easily available and visible for all residents.
• Training on Safeguarding and Protection for residents is scheduled for 14/11/2019 and this will be conducted by Designated Officers who are familiar to residents within this service.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
HSE CHO1 Disability Services is committed to ensuring that residents' rights and freedom to make choices are promoted in all aspects of their lives. To this end, the following actions will be taken:

• Supporting resident's rights and residents' freedom to make choices and have control in their daily lives will be incorporated as a specific area within the staff supervision process for all staff within Rosenheim Services.
• Protected time within the resident's meetings held in each house across the designated centre will be allocated to the following standing items:
o Choice in food and shopping
o Social Events
o Work
o Day to day running of the home
This will be followed up with daily consultation and discussion with residents on the agreed plans for each week.
• In respect of food choices and mealtimes, food diaries have been introduced as of 30/10/2019.
• In addition, all staff within the centre will receive International Dysphagia Diet Standardisation Initiative training on mealtimes. This is scheduled to be completed by 31/12/2019.
• Staffing across the designated centre has been reviewed and the following has been put in place:
o The sleepover roster in Houses 136 and 137 has been replaced by a waking roster

including an additional 1 WTE support as of 06/11/2019.
o An additional 1 WTE has been assigned to House 137 to allow for 24 hour support in each house independently as of 04/11/2019.
The impact of the above staffing changes, is to make available social support hours to ensure residents have the opportunity to participate in activities in line with their wishes.

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(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/11/2019
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	18/11/2019
Regulation 15(1)	The registered provider shall ensure that the	Not Compliant	Orange	06/12/2019

	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.			
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	06/12/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/03/2020
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.	Substantially Compliant	Yellow	31/03/2020
Regulation 17(7)	The registered provider shall	Not Compliant	Orange	31/03/2020

	make provision for the matters set out in Schedule 6.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	18/11/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	18/11/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	18/11/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the	Not Compliant	Orange	10/11/2019

	event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	10/11/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	25/10/2019
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	30/11/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional,	Substantially Compliant	Yellow	30/11/2019

	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.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/11/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	21/11/2019
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	21/11/2019
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	Not Compliant	Orange	08/11/2019

	disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
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	08/11/2019