Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation of Health and Social Care Services

Guidance for the assessment of centres for persons with disabilities

Updated June 2022

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.
HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Office of the Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

- **Health Information —** Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Contents

1. About the Guidance

1.1 Introduction

The Health Information and Quality Authority (HIQA) through the Chief Inspector of Social Services is responsible for registering and inspecting designated centres and assessing whether the registered provider is in compliance with the regulations and standards.

It is the responsibility of each registered provider and persons who participate in the management of designated centres to ensure they are delivering a safe and effective service that complies with the regulations and standards and any other legislation.

In order to carry out its functions as required by the Health Act 2007 as amended, HIQA has adopted a common Authority Monitoring Approach (AMA). All HIQA staff involved in the regulation of services or the monitoring of services against standards are required to use this approach and any associated policies, procedures and protocols. HIQA's monitoring approach does not replace professional judgment. Instead, it gives a framework for staff to use professional judgment and supports them to do this. The aim of AMA is to ensure:

- a consistent and timely assessment and monitoring of compliance with regulations and standards
- a responsive and consistent approach to regulation and assessment of risk within designated centres
- contribute to the improvement of the service being inspected through application of the inspection process.

Among its functions, HIQA promotes improvement in the quality and safety of health and social care services. Compliance with the regulations is a minimum requirement. In order to improve the quality and safety of social care services, service providers are encouraged to look beyond the regulations and to continually seek improvements in the services they provide to residents.

1.2 Scope

This guidance relates to designated centres to which the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities apply.

1.3 Purpose

This guidance should be used in conjunction with the revised assessment judgment framework, which is one of the tools HIQA uses to assess compliance with the regulations and standards. The assessment judgment framework supports inspectors

in gathering evidence when monitoring or assessing a designated centre and to make judgments on compliance. It sets out the lines of enquiry to be explored by inspectors in order to assess compliance with the regulations and or standards being monitored or assessed. This should also be used by providers to self-assess their own service.

Inspectors will use this guidance alongside the assessment judgment framework. The purpose of the guidance is to provide additional supporting information to inspectors on assessing compliance and offer guidance on reviewing each regulation and standard.

Therefore, the guidance gives greater detail on how to assess and what to review during fieldwork planning, gathering of relevant information and evidence onsite and the making of judgments about compliance.

Furthermore, this guidance facilitates a consistent approach to conducting inspections by:

- supporting inspectors in developing a clear understanding of the regulations
- providing direction to providers and persons in charge on the type of findings that could demonstrate evidence of compliance and non-compliance.

The guidance also includes a section on what a service striving for improvement would look like. The intention of this section is that where providers meet the requirements of the regulations, they should be seeking to constantly strive for ongoing improvements in the quality of the service.

2. Assessing compliance

2.1 Inspection

HIQA carries out inspections in order to assess compliance with the regulations and standards. Before an inspection, HIQA comprehensively reviews information on the centre to inform what needs to be reviewed on inspection. Throughout inspections, the views of people who use the service are sought. While inspections are normally unannounced, a centre can expect at least one announced inspection in the three-year registration cycle.

While all inspections afford residents and people who visit the centre an opportunity to express their views on the service, the purpose of an announced inspection is to give residents and their relatives advanced notice.

In order to make judgments about compliance, HIQA will:

- communicate 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 and deliver care and services — conversations with management and staff will concentrate

on their understanding of areas relevant to their work and care they deliver, their experience and training
- observe practice and daily life to see if it reflects what people have stated
- review documents to see if appropriate records are kept and that they reflect practice and what people have stated.

It is important to remember that a residential care setting is a person's home and inspectors are visitors in that home. Therefore, while an inspection can be disruptive, changes to the residents' or the staff's normal routine are not expected and should be minimized.

At the beginning of the inspection, inspectors introduce themselves and outline the purpose and duration of the inspection to the person in charge and registered provider if available. The person in charge is asked to inform both residents and staff that HIQA is conducting an inspection and introduce the inspectors to residents, where appropriate to do so. While inspectors have powers of entry and inspection, these will be exercised in a respectful manner and have cognisance of each resident's rights. Observation on inspection should be unobtrusive, discrete and not negatively impact on service provision. Residents' dignity and human rights must be respected at all times.

HIQA [1]inspections are carried in line with Department of Health, HPSC, and HSE guidance.

2.2 When are inspections carried out?

All inspections and monitoring activity inform the registration of a designated centre. This includes new applications and renewal of registrations.

HIQA takes a risk-based approach to regulation. This means that regulatory activities are prioritised and resources relating to monitoring, inspection and enforcement are organised based on the assessment of the risk that the regulated services pose.[2]

This approach informs how frequently HIQA inspects any individual designated centre. It also informs the nature, intensity and type of any inspection carried out.

HIQA carries out the following types of inspection:

- *Monitoring inspections:* these are routine inspections that monitor the quality of the service provided at a designated centre and the level of compliance.
- *Targeted (focused risk) inspections:* these are in addition to routine inspections and are carried out when information has been received that indicates that there may be a risk posed to residents.

[1] Including those conducted by inspectors of social services
[2] Better Regulation Commission, 2006

- *Thematic inspections:* these inspections are part of a programme which aims to drive quality improvements related to a specific theme in the regulated sector, for example, a restrictive-practice thematic programme.

2.3 Judgments on compliance with regulations

Once inspectors have gathered information, they make a judgment about the level of compliance against each regulation reviewed.[3] While some regulations attribute responsibility to the person in charge to comply, overall responsibility for compliance is with the registered provider. Inspectors will judge whether the registered provider or person in charge has been found to be **compliant, substantially compliant** or **not compliant** with the regulations associated with them.

The compliance descriptors are defined as follows:

Compliant: a judgment of compliant means the provider and or the person in charge is in full compliance with the relevant regulation.

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 will identify 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.

Once a judgment on compliance is made, inspectors will review the risk to residents of the non-compliance. Inspectors will report on this risk as:

- Red: there is high risk associated with the non-compliance
- Orange: there is moderate risk associated with the non-compliance
- Yellow: there is low risk associated with the non-compliance
- Green: there is no risk.

[3] Judgments are also made on compliance with the standards; however, the judgement descriptors are reported on against the regulations.

2.4 Reporting the findings

The inspector will give feedback to the registered provider/person in charge or their delegate on the preliminary[4] findings from the inspection. The inspector then writes up an inspection report to summarise the findings.

In order to summarise the inspection findings, the regulations are grouped under two dimensions which are aligned with the standards:

- **Capacity and capability of the registered provider to deliver a safe quality service:** This section describes the governance, leadership and management arrangements in the centre and how effective they are in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and supported through education and training, and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.
- **Quality and safety of the service:** This section describes the care and support people receive and whether 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.

3. Structure of the guidance on each regulation

Guidance on each individual regulation from 3 to 34 is presented in the following section. Each regulation is described in five sections, namely, the standards associated with the regulation, where applicable; examples of the information/evidence reviewed to assess compliance; indicators which demonstrate the registered provider's and or person in charge's level of compliance with the regulations and standards; risk rating of compliance; and what a service striving for quality improvement looks like. The section on what a service striving for quality improvement looks like is based on the Standards and international research.

In addition, Appendix 1 lists regulations identified as having an association with the primary regulation being reviewed and that may need to be considered. Notwithstanding the association of the related regulations, judgment on the primary regulation is made independently of the other related regulations.

Part 1: The standard associated with the regulation, where applicable

Where a standard is directly linked to a regulation, it is listed. While a number of standards can be related to one or more regulations, for the purposes of inspection

[4] Preliminary feedback does not include a full evaluation of the findings of an inspection. Feedback will be given in line with HIQA internal fieldwork guidance.

and reporting a 'best fit' approach to the standards is taken and the standard is linked to the most relevant regulation.

Part 2: What a service striving for quality improvement looks like

Where a regulation has been complied with, it is incumbent on providers to seek out ways to continuously improve the quality of their service and outcomes for residents. This part of the guidance outlines examples of what residents can expect of a service that is striving for quality improvement. We will acknowledge and report on improvements and quality initiatives.

Part 3: Examples of the information/evidence reviewed to assess compliance

This part gives examples of information/evidence that are reviewed to assist with assessing compliance. The examples are listed under the headings of observation, communication and documentation. These examples will support the planning of an inspection, gathering of information on site and the making of judgments about compliance.

The types of information reviewed will be determined by the history of compliance, specific areas of risk and outcome of the inspection planning. As part of this planning, inspectors will review documentation about this centre.

Part 4: Indicators which demonstrate the registered provider's and or person in charge's level of compliance with the regulations and standards

Compliance with the regulations and standards is the overall responsibility of the registered provider. The inspections give the registered provider and person in charge an opportunity to demonstrate how they have complied with the regulations and standards. The expectation is that providers continuously review and assess their service and put measures in place to comply with the requirements as laid out in the regulations and standards. The regulations are a minimum requirement, and the standards are intended to drive continuous quality improvement.

The examples detailed are not an exhaustive list but are there to assist determining the levels of compliance.

Part 5: Risk rating of compliance

The level to which designated centres have complied with the regulations have an impact on outcomes for residents. In order to improve outcomes for residents, compliance with regulations are risk rated.

Each regulation can be assigned a maximum risk rating based on the severity of impact on residents and the likelihood of occurrence/recurrence. Continued non-compliance resulting from a failure of a provider to put appropriate measures in place to address the areas of risk may result in escalated regulatory action.

4. Guidance

4.1 Guidance on regulations related to capacity and capability

This section describes regulations related to the leadership and management of the centre and how effective they are in ensuring that a good quality and safe service is being provided. It considers 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.

Regulation 3	Statement of purpose
Standard 5.3	The residential service has a publicly available statement of purpose that accurately and clearly describes the services provided.

What a service striving for quality improvement looks like

The statement of purpose promotes transparency and responsiveness by accurately describing the designated centre's aims and objectives and the services provided, including how and where they are provided. The service that is defined in the statement of purpose is reflected in other related policies and procedures.

A good statement of purpose recognises the intrinsic value of the person using the service. It includes statements treating people with respect and dignity, recognising and promoting people's individuality and maximising their independence and autonomy. It also recognises their rights as individuals cognisant of their diagnosis and ability and shows that the service is designed and delivered to meet those specific needs.

The statement of purpose clearly describes the model of care and support delivered to residents in the service. It reflects the day-to-day operation of the designated centre, and it is reviewed regularly and updated when necessary. It is publicly available and communicated to people living in the residential service and their families in an accessible format.

The review and evaluation of the statement of purpose is incorporated in the service's governance arrangements to provide assurance that services and facilities are being delivered within the scope of the statement of purpose. This is part of the continuous quality improvement cycle, which, in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed

Through observation

Inspectors will observe:

- to determine if the statement of purpose accurately reflect the facilities and services provided. For example, cross check the description of the rooms, including their size and main function, and check if there are any specialised facilities.
- to establish if the statement of purpose is clearly demonstrated in practice. For example, does the centre provide the specific care and support documented in the statement of purpose or are there residents with specific needs that are not described in the statement of purpose? Does the organisational structure reflect the actual reporting structures? Are the activities as described in the statement of purpose provided to residents?
- to determine if the statement of purpose has been made available to residents and their representatives.

Through communication

Inspectors will communicate:

- with residents to determine if they are aware of the statement of purpose
- to confirm whether a copy of the statement of purpose has been made available to residents and or their families/representatives where applicable
- to establish if the registered provider and person in charge are familiar with the content of the statement of purpose and whether they are satisfied that it reflects practice.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during inspection
- the statement of purpose to ensure that it contains all the required information, including that which is prescribed in Schedule 1; that the current version is available in the centre; and that the registered provider has reviewed and, where necessary, revised the statement of purpose when required.

Additional documents that may be reviewed include:

- residents' contracts of care
- admission records
- minutes of residents' meetings
- satisfaction surveys
- the complaints register
- the residents' guide
- the annual review.

Compliance indicators

Indicators of compliance include:

- the statement of purpose is in place and includes all information set out in associated schedule
- the statement of purpose is reviewed when required
- a copy of the statement of purpose is available to residents and their representatives.

Indicators of substantial compliance include:

- the statement of purpose is available but does not include some information set out in the associated schedule
- there is evidence of reviews and necessary revisions of the statement of purpose but not as frequently as required although they do happen within a relevantly short period afterwards

- the statement of purpose is made available to residents but not their representatives.

Indicators of non-compliance include:

- there is no written statement of purpose
- the statement of purpose does not include much of the information set out in the associated Schedule
- the statement of purpose is not kept under review or revised when necessary
- the written statement of purpose is not made available to residents and their representatives.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or Red

Note: This may be risk rated red where the registered provider does not identify the specific care and support needs that the service intends to meet nor do they accurately describe the service being provided within the statement of purpose.

Regulation 4 Written policies and procedures

What a service striving for quality improvement looks like

Policies and procedures are not considered in isolation to the systems in place to ensure safe and effective care. The policies and procedures are essential for the safe delivery of care and to guide staff in delivering safe and appropriate care. They are about good governance from a provider perspective, and they are 'living' documents that are used by staff and reviewed and updated as required.

The registered provider has ensured that they have the relevant policies and procedures specific to the care needs and service that is provided in each individual service.

A robust information governance system is in place, with responsibility assigned to ensure that there are written policies and procedures in place and are adapted to the service to reflect current practice.

The registered provider has ensured that the policies and procedures are consistent with relevant legislation, professional guidance and international best practice. They are written for the service, clear, transparent and easily accessible. There is clear evidence that staff understand and use the centre's policies and procedures to deliver a safe and quality service.

Evaluation of the effectiveness of written policies and procedures are an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

The centres polices have been reviewed and updated in line with HPSC, HSE and Governmental guidance and these changes with any associated supports required to implement them have been given to staff, or staff have access to up-to-date guidance issued by the Health Protection Surveillance centre (HPSC) from time to time.

Where policy and procedure changes impact on the daily lives of residents, the reason for the changes are communicated to residents in an assessable way.

Staff know about changes and improvements to policies and procedures in response to changes in legislation and best practice research. Staff confirm their awareness, knowledge and understanding and access to policies and procedures. Staff confirm their feedback is sought and they have input into policy development relevant to their roles and responsibilities.

Practice in the centre reflects best practice, and the impact on outcomes for people is positive.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- if the policies are pertinent to the individual service or if they are generic in nature
- if they reflect practice and have they been amended when required, for example, when resident needs have changed or based on changing HPSC, HSE or Governmental specific guidance
- if the policies and procedures reviewed are consistently implemented in practice and if they have a positive impact on the outcomes for residents and support residents' rights.
- practice and, if unacceptable practice is identified, review the relevant policy
- to verify if staff are working in accordance with the centre's Schedule 5 policies and procedures
- to see how staff access the policies and procedures.

Through communication

Inspectors will communicate:

- with residents to explore their experience of living in the centre and that their rights, independence and safety are promoted?
- with the registered provider/person in charge to determine how they have ensured that staff understand and consistently implement the policies and procedures
- with staff to establish if there is a system in place to inform staff of any changes to policies and procedures
- with staff to ascertain if they are aware of changes to practice arising from Public Health guidance or directions and are supported to implemented them
- with staff to determine if they can demonstrate sufficient knowledge of the policies and procedures relevant to their work. For example, are they familiar with the care of residents that they are supporting?
- with staff to determine if there are opportunities for staff to discuss the content of the policies and procedures and their effectiveness with the registered provider and or person in charge.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during inspection
- written policies and procedures as per Schedule 5 and determine if the Schedule 5 policies and procedures have been reviewed when necessary, for example, to

reflect changes in law and residents' needs and HPSC, HSE and Governmental specific guidance.

Additional documents that may be reviewed include:

- supplementary policies, procedures and guidelines to support specific care needs
- the statement of purpose
- the annual review.

Compliance indicators

Indicators of compliance include:

- all Schedule 5 written policies and procedures are adopted and implemented, made available to staff and reviewed when required
- all Schedule 5 policies and procedures are reviewed as often as the Chief Inspector may require and are at least reviewed and updated at intervals not exceeding 3 years and, where necessary, to reflect best practice and HPSC, HSE and Governmental guidance.

Indicators of substantial compliance include:

- while written policies and procedures are adopted and implemented, some gaps are evident in the maintenance and update of the documentation such as updates based on HPSC, HSE and Governmental guidance.
- Schedule 5 policies and procedures have been implemented into practice but some are not readily available to staff
- Schedule 5 policy requires review. For example, the registered provider and person in charge have taken adequate measures to protect residents from being harmed and from suffering abuse; however, some improvement is required to the policy on preventing abuse and responding to allegations or suspicions of abuse to reflect evidence-based practice.

Indicators of non-compliance include:

- Schedule 5 written policies and procedures have not been prepared in writing, adopted or implemented
- there is no policy on, for example, access to education, training and development
- while there is a policy on, for example, access to education, training and development, staff are not sufficiently knowledgeable about it
- Schedule 5 policies and procedures have been prepared in writing and adopted but not implemented into practice
- while there is a policy in place, for example, on the provision of behavioural support, staff are not familiar with it
- all Schedule 5 policies and procedures have not been reviewed and updated to reflect best practice and or at intervals not exceeding 3 years

- all Schedule 5 policies and procedures are not reviewed as often as the Chief Inspector may require.
- HPSC, HSE and Department of Health advice has not been taken into account when updating policies and procedures
- Staff do not have access to or supported to implement HPSC, HSE and Department of Health guidance.

Guide to the risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Note: If there is a complete lack of polices and there is a negative impact on care, then the non-compliance is risk rated red. If the required policies are in place and there is limited negative impact on residents, then the non-compliance is not rated higher than orange.

Regulation 14 Person in charge

What a service striving for quality improvement looks like

The person in charge has a clear understanding and vision of the service to be provided. The person in charge, supported by the provider, fosters a culture that promotes the individual and collective rights of the residents. The person in charge has a strong focus on person-centred care and manages the centre in ways that avoids institutional procedures. The person in charge ensures a rights-based approach to care is delivered. She/he oversees the service effectively and ensures that, in practice, residents receive a quality and safe service where the core human rights principles (fairness, respect, equality, dignity and autonomy) of residents are to the fore.

The person in charge is engaged in effective governance, and the registered provider has ensured that she/he is a fit person in line with HIQA's guidance on fitness. The person in charge has demonstrated that she/he can lead a quality service and has developed a motivated and committed team that are suitably skilled, kind, caring and creative. This team, led by the example of the person in charge, supports residents to live active lives having due regard to their needs and wishes. A learning culture is promoted through training and professional development along with the service's quality improvement strategy. As part of the learning and development programme the person in charge should identify the appropriate staff members who can cover during absences and ensure that effective and sustainable leadership and governance can continue during any period of planned or unplanned absences.

The person in charge supports a culture of openness where the views of all involved in the service are sought and taken into consideration. The person in charge promotes and advocates for residents to be active participants in their own care. The residents know the person in charge. The person in charge is familiar with the residents' needs and ensures that they are met in practice. The person in charge supports residents to maintain and develop new interests and hobbies.

There is clear evidence the person in charge is competent, with appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service and meet its stated purpose, aims and objectives. The person in charge is very familiar with the organisational reporting structure in place and knowledgeable about the requirements of the Health Act 2007, regulations and standards. The person in charge also demonstrates appropriate knowledge of relevant best practice and guidance. Periodically, with the support of the registered provider, the person in charge evaluates his or her own personal strengths or challenges and proactively seeks out areas for development.

Depending on the size and complexity of the service, the person in charge may not be involved in day-to-day care arrangements for each resident, but they will have systems in place to assure themselves that care is delivered to a high standard; that residents privacy, dignity and rights are protected; and that their wellbeing is always at the core of the ethos of the service.

The person in charge has the authority to affect change and ensure that care delivered to residents is of a high standard. Where the role of person in charge is shared, each person has a clear understanding of and accountability for their roles and responsibilities. Where the person in charge is in charge of more than one centre, they delegate daily oversight appropriately and have systems and structures in place to assure that care is delivered as expected.

The registered provider and the person in charge are constantly seeking to improve the quality and safety of the service. They evaluate compliance with the regulations and standards that are specifically their responsibility and implement a structured quality improvement programme to address any deficits and drive quality improvement initiatives. They take appropriate action following monitoring, inspection or investigation activities relating to the service. New and existing legislation and national policy are reviewed on a regular basis to determine what is relevant to their service and how it impacts on practice, and if there are any gaps in compliance that they are addressed.

Evaluation of the effectiveness of governance and management and, in particular, the role of the person in charge underpins quality improvement. This is part of the continuous quality improvement cycle, which, in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- if the person in charge is the same as the one notified to HIQA
- if the person in charge can demonstrate in practice that she/he has the necessary qualifications, skills and experience to manage the centre. (The inspector may need to explore components of fitness further under a fitness assessment if queries are identified)
- if the person in charge is appointed for more than one centre whether there is effective governance, operational management and administration of the centre being inspected so that there are positive outcomes for all residents.

Through communication

Inspectors will communicate:

- with the residents and, where appropriate, families to determine if they know who the person in charge is, what his or her role is and their views on the effectiveness of the person in charge
- with the person in charge throughout the regulatory process to establish the person in charge's level of oversight and engagement with the service or when there is a change in person in charge

- with the person in charge to establish that the post is full-time, find out that she/he meets the requirements of the regulations and determine if the person in charge has a clear vision for the centre with a strong focus on person-centred care
- with the registered provider and person in charge in situations where the person in charge oversees more than one centre in order to establish if the person in charge has ensured effective governance, operational management and administration of each centre
- with the registered provider and person in charge in situations where there is more than one person fulfilling the post of person in charge to determine if this arrangement ensures continuity in the centre
- with staff to determine their understanding of the role of person in charge and the governance and reporting structures within the centre, including arrangements when the person in charge is absent
- with staff to establish their views on the effectiveness of the person in charge. For example, how does the person in charge ensure that staff receive appropriate induction, professional development and supervision?

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- any resident questionnaires received prior to and during the inspection
- for registration inspections, the application and relevant documents
- fitness assessment notebook
- statement of purpose
- staff rotas — planned and actual
- the person in charge's human resources file in order to check that the post of person in charge is full-time and to examine the person in charge's terms and conditions of employment and written job description.
- notifications to HIQA
- staff files, including any arrangements for staff support, development and performance management.

Compliance indicators

Indicators of compliance include:

- there is a full-time post of person in charge in the centre
- the centre is managed by a suitably skilled, qualified and experienced person in charge
- the person in charge is engaged in the governance, operational management and administration of the centre on a regular and consistent basis
- if the person in charge manages more than one designated centre, she/he has ensured the effective governance, operational management and administration of the designated centres concerned

- the person in charge (if appointed on or after 1 November 2016) has at least three years' experience in a management or supervisory role in the area of health or social care
- the person in charge (if appointed on or after 1 November 2016) has an appropriate qualification in health or social care management at an appropriate level. (This qualification must be accredited and commensurate with the role that they are fulfilling)

Indicators of substantial compliance include:

- there are minor gaps identified in the documentation
.

Indicators of non-compliance include:

- the person in charge does not have the required qualifications, skills or experience necessary
- the role of the person in charge is not full-time
- the person in charge manages more than one designated centre and cannot ensure the effective governance, operational management and administration of the designated centres concerned.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or Red

Regulation 15	Staffing
Standard 7.1	Safe and effective recruitment practices are in place to recruit staff.

What a service striving for quality improvement looks like

Each staff member has a key role to play in delivering person-centred, effective, safe care and support to the residents. Residents report that staff are kind and respectful. In addition, residents say that their core human rights of fairness, respect, equality, dignity and autonomy are upheld by staff.

The culture and ethos of the organisation is embodied by staff who clearly recognise their role as advocates and that they are caring for residents in their own home. Staff facilitate a supportive environment at all times, and this enables residents to feel safe and protected from all forms of abuse. Staff support residents' independence and only provide supports where required. Staff have the necessary competencies and skills to support the specific residents that live in the centre and have developed therapeutic relationships with residents.

The service uses the necessary tools to assess and ensure that appropriate staffing levels and skill mix are in place so that each resident's needs are met. Staffing ratios enable flexibility to respond to residents' changing needs and the way they wish to live their lives. Staff recruitment ensures that only those who were committed to offering excellent care are employed.

There are at all times sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents living in the service and which reflects the size, layout and purpose of the service. Staff are always available to ensure the safety of residents, and contingency plans are in place in the event of a shortfall in staffing levels.

There is continuity of staffing so that attachments are not disrupted. The continuity of support and the maintenance of relationships are promoted through strategies for the retention of staff and ensuring sufficient staffing levels to avoid excessive use of casual, short-term, temporary and agency workers.

The person in charge and provider ensure that they have contingency plans in place to respond quickly and ensure continuity of care to resident in the event of a shortfall of staff. On-call arrangement are clear and communicated to all staff which supports access to managerial and clinical support and advice at all times as appropriate.

Evaluation of effectiveness of staffing arrangements consists of an element of the continuous quality improvement cycle, which, in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- staff practices and interactions with residents to determine if there are enough suitable staff on duty
- whether staff have the necessary skills to meet residents' needs, that these needs are being met and that residents are safe.
- whether the atmosphere in the centre is rushed. For example, look to see if call bells or other requests for support are answered promptly
- where applicable, if cover arrangements are in place for staff absences
- staff handovers to see how staff are deployed and how the shifts are covered to meet residents' needs
- where there are residents with nursing needs that require the support of a nurse, that a nurse is available
- if the planned and actual staff rotas correspond.

Through communication

Inspectors will communicate:

- with residents to establish their view and experience on staffing in the centre. For example, enquire how staffing levels impact on their daily lives. This may also include talking to their relatives and friends, advocates and any visiting professionals
- with the registered provider to confirm how they ensure that staffing is appropriate
- with staff and the person in charge to hear their views on staffing arrangements. For instance, ask how shifts are managed, especially at weekends and night time; how are staffing levels maintained or increased at busy times; and how staff are employed to meet the different needs of residents
- with residents and staff to check if there have been any incidents that have occurred due to a lack of staffing
- with the person in charge about the recruitment process and contingency plans should unexpected staff shortfalls occur
- with the person in charge to determine, in situations when staff are employed on a less than full-time basis, how the provider/person in charge/person participating in management ensure that this does not cause a negative impact on residents and that residents' continuity of care is maintained.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the recruitment, selection and Garda Vetting of staff policy, if received
- Staff rosters (planned and actual)
- locum cover arrangements or guidance in relation to staff replacement
- staff training plan/matrix
- a sample of staff files

- the relevant current registration status with professional bodies for nursing and other health and social care professionals that work in the centre.

Additional documents that may be reviewed:

- residents' personal plans, including risk assessments
- minutes of residents and staff meetings
- accidents and incidents register
- records of complaints
- call bell logs, if available, in order to further triangulate and support the evidence if there are concerns
- audits relating to staffing
- surveys
- the annual review.

Compliance indicators

Indicators of compliance include:

- there is enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times
- nursing care is provided in line with the statement of purpose and the assessed or changing needs of residents
- in services where nurses are employed to carry out nursing care, the nurses are appropriately registered
- staffing levels take into account the statement of purpose and size and layout of the building
- there is an actual and planned staff rota
- the provider and person in charge have arrangements in place to respond quickly to staff shortages to ensure continuity and appropriate care
- residents receive assistance, interventions and care in a respectful, timely and safe manner and there is continuity of care.
- information and documents specified in Schedule 2 are available.

Indicators of substantial compliance include:

- there are enough staff on duty to meet the assessed needs of residents but the planned rota does not fully match the staff on duty
- while contingency plans for staffing in place are available they require strengthening
- gaps are identified in the documentation but they do not result in a medium or high risk to residents using the service.

Indicators of non-compliance include:

- the staffing levels and skill mix are not enough to meet the assessed needs of residents
- there is evidence of negative outcomes for residents due to staff shortages
- residents' needs could not be met as staff members lacked the required skills or qualifications to support and care for them

- where residents are assessed as requiring nursing care, none is provided
- residents are not adequately supervised to ensure their needs are being met
- residents are not adequately supervised during staff handovers
- there is no planned and or actual staff rota in place
- there are enough staff to meet the assessed needs of residents but no contingencies are in place to cover staff on annual leave or sick leave
- there are enough staff to meet the assessed needs of residents but staffing is not arranged around the needs of residents
- staff are slow to respond to residents at different times of the day or night
- gaps identified in the documentation resulted in significant risk to residents using the service. For example, no Garda vetting and issues of safety identified.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 16	Training and staff development
Standard 7.2	Staff have the required competencies to manage and deliver child-centred, effective and safe services to children.
Standard 7.2	Staff have the required competencies to manage and deliver person-centred, effective and safe services to adults living in the residential service.
Standard 7.3	Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of children.
Standard 7.3	Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of adults living in the residential service.
Standard 7.4	Training is provided to staff to improve outcomes for children.
Standard 7.4	Training is provided to staff to improve outcomes for adults living in the residential service.

What a service striving for quality improvement looks like

Staff are supported to develop professionally in an atmosphere of respect and encouragement. All staff are trained to provide safe person-centred services and supports to residents which are underpinned by an approach that upholds the resident's core human rights principles of fairness, respect, equality, dignity and autonomy.

Each staff member has a key role to play in delivering person-centred, effective and safe residential services and supports to residents. The workforce is organised and managed in such a way to ensure that staff have the required skills, experience and competencies to respond to the needs of residents with disabilities. Key workers have the skills required to plan and coordinate care and supports and to liaise effectively with other organisations and professionals.

A training needs analysis is completed periodically with all staff, and relevant training is provided as part of a continuous professional development (CPD) programme. As aspects of service provision change and develop over time, the service supports staff to continuously update and maintain their knowledge and skills. The training needs of the workforce are regularly monitored and addressed to ensure the delivery of high quality, safe and effective residential services for people with disabilities. Infection prevention and control capability and knowledge within the centre is developed and maximized.

All staff receive support and supervision by appropriately qualified and experienced personnel to ensure that they perform their duties to the best of their ability. Those who supervise staff are provided with training in supervision theory and practice.

There is a written code of conduct for all staff, developed in consultation with residents. Staff also adhere to the codes of conduct of their own professional body or association and or professional regulatory body.

Evaluation of the effectiveness of training and staff development consists of an element of the continuous quality improvement cycle, which, in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- if staff interactions with residents demonstrate that appropriate training has been received. For example, resident's individual needs are being met or it may highlight areas for professional development
- staff handovers to ascertain the level of knowledge staff have
- that appropriate supervision arrangements are in place
- that copies of the Health Act 2007, regulations, HIQA's standards and any relevant guidance are made available to staff.

Through communication

Inspectors will communicate:

- with residents to get their view and experience on whether staff are sufficiently trained, skilled and experienced to provide appropriate care and support that enables them to have a quality of life that is in keeping with their needs and wishes.
- with the person in charge and staff about supervisory arrangements
- with staff about their induction, support and training and whether they feel this has enabled them to care for and support residents effectively when they started work and on an ongoing basis, noting any examples given
- with staff to determine if they are informed of the Health Act 2007 and regulations anc standards made under the Act.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- staff training and development policy
- recruitment, selection and Garda vetting of staff policy
- staff training and development attendance records
- staff training records
- continuing professional development programme/training matrix.

Additional records that may be reviewed:

- staff appraisal/supervision records
- the annual review.

Compliance indicators

Indicators of compliance include:

- the education and training available to staff enables them to provide care that reflects up-to-date, evidence-based practice
- staff receive ongoing training as part of their CPD that is relevant to the needs of residents
- education and training provided reflects the statement of purpose
- staff are able to deliver care and support to residents because their learning and development needs have been met
- staff are aware of the current legislation, including the Health Act 2007, the regulations and the standards
- staff are supervised appropriate to their role
- quality supervision is in place that improves practice and accountability
- there are effective recruitment procedures in place that includes checking and recording all required information
- the requirements of the Schedule relating to staff documentation have been met
- all relevant members of staff have an up-to-date registration with the relevant professional body, if this is required.

Indicators of substantial compliance include:

- gaps are identified in the documentation but they do not result in a medium or high risk to residents using the service
- staff are informed of the Health Act 2007 and the regulations and standards made under the Act but copies are not available to them
- staff have received relevant training, demonstrate knowledge and competence in these areas and have implemented this training into practice resulting in positive outcomes for residents; however, some of these staff members have not completed refresher training.

Indicators of non-compliance include:

- staff have very limited or no access to appropriate training
- a training programme is in place for staff but some staff have not received mandatory training
- staff have received training but there is evidence that training is not always put into practice
- staff do not have the skills to care for residents with specialist care needs

- staff are not supervised pertinent to their role and responsibilities
- staff receive inadequate supervision as evidenced in the negative outcomes for residents
- staff have no awareness of the Health Act 2007 and or the regulations and or the standards made under the Act
- staff have no access to the Health Act 2007, regulations, standards and other relevant guidance.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 19 Directory of residents

What a service striving for quality improvement looks like

A robust information governance system is in place with responsibility assigned to ensure that the directory of residents contains all the required information and is comprehensively maintained.

Evaluation of how effectively the directory of residents is maintained consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- if the directory of residents is maintained up to date. For instance, check that residents living in the centre are recorded on the register.

Through communication

Inspectors will communicate:

- with residents to establish information such as when they were admitted to the centre and had they been in hospital
- with the person in charge regarding the arrangements for maintaining the directory of residents
- with staff to check details that relate to the directory of residents such as were any residents recently admitted to or returned from hospital.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- directory of residents.

Additional documents that may be reviewed:

- residents' contracts for the provision of services
- documents that relate to the centre admission and discharge processes such as pre-admission assessment and discharge notes
- the annual review.

Compliance indicators

Indicators of compliance include:

- the directory of residents is made available, when requested
- the directory of residents is up to date with all the required information.

Indicators of substantial compliance include:

- the directory of residents was generally up to date but some required information was absent.

Indicators of non-compliance include:

- there was no directory of residents
- the directory of residents was not up to date
- the directory of residents did not contain most of the requirement information.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange

Regulation 21	Records
Standard 8.2	Information governance arrangements ensure secure record-keeping and file-management systems are in place to deliver a child and adult person-centred, safe and effective service.

What a service striving for quality improvement looks like

Record keeping is a fundamental part of practice and is essential to the provision of safe and effective care. There is a clear understanding that good record keeping has a number of important functions such as:

- improving communications
- supporting delivery and continuity of care for the resident
- demonstrating decision making
- identifying risk for residents
- safeguarding residents.

There is a system in place that ensures records are up to date, of high quality and accurate at all times, and this supports the effective and efficient running of the centre. Information is appropriate, accessible and, where information confidential in nature, it is ethically used and securely maintained to protect the rights, including privacy, of the residents. There are also appropriate systems in place for the safe archiving, destruction and backup of records.

Relevant management and staff are aware of their roles and responsibilities regarding the management of these records.

Evaluation of the effectiveness of record management consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- if records are available for inspection
- if records are appropriately maintained in the centre
- whether a sample of records examined on inspection reflect practice.

Through communication

Inspectors will communicate:

- with residents to determine if they can access their records
- with the provider/person in charge to determine what systems are in place to ensure records are held in accordance with the regulations

- with staff to explore their understanding of the systems that are in place to appropriately maintain records.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during inspection
- staff records for those currently and previously employed at the centre
- residents' records
- records such as the statement of purpose, the Residents' Guide and inspection reports
- the annual review.

Compliance indicators

Indicators of compliance include:

- records are maintained and available for inspection
- records are accurate and up to date
- records are kept secure but easily retrievable
- residents can access their own records
- staff records, residents' records and other records are kept for the required timeframe
- records that relate to children are kept in perpetuity and transferred to the HSE within the required timeframe from the date the child stopped living in the centre
- records relating to inspections by other authorities (fire/food safety/health and safety) are maintained.

Indicators of substantial compliance include:

- while it is evident that care is delivered to a high standard, gaps are identified in the documentation; however, these gaps do not result in a medium or high risk to residents
- records are maintained but are not easily retrievable
- records are maintained but there are some inaccuracies
- all inspection reports are not available.

Indicators of non-compliance include:

- records set out in the schedules have not been maintained
- required records are not available for inspection
- some residents' records are not complete. For example, there are no records of residents' money, valuables or furniture
- records are not kept for the required timeframes.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange

Regulation 22 Insurance

What a service striving for quality improvement looks like

A robust information governance system is in place, with responsibility assigned to ensure that the building and all contents, including residents' property, are insured. A valid insurance certificate or written confirmation of insurance cover is available to confirm that insurance is in place.

There is appropriate insurance in place against risks in the centre, including injury to residents. Residents and or representatives have been advised about this insurance.

Evaluation of how effectively governance and management practices are consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- where an insurance claim has been made against lost or damage to residents' belongings that, where possible, these items have been replaced.

Through communication

Inspectors will communicate:

- with residents to determine if they have been advised of the insurance in place, where applicable
- with the person in charge to determine their understanding of the insurance that is in place.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the contract of insurance

Compliance indicators

Indicators of compliance include:

- the centre is insured against accidents or injury to residents
- residents and or their representatives have been advised when insurance for risks such as loss or damage to property has been put into effect.

Indicators of non-compliance include:

- there is no insurance for the centre
- residents and or their representatives have not been advised that insurance is in place.

Guide for risk rating:

Compliant	Non-compliance
Green	Orange

Regulation 23	Governance and management
Standard 5.1	The residential service performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect each child and adult, and promote their welfare.
Standard 5.2	The residential service has effective leadership, governance and management arrangements in place with clear lines of accountability.
Standard 6.7	The use of available resources is planned and managed to provide child-centred effective residential services and supports to children.
Standard 6.7	The use of available resources is planned and managed to provide person-centred effective and safe residential services and supports to adults living in the residential service.

What a service striving for quality improvement looks like

Effective governance ensures positive outcomes for residents using the service through care and support that is person-centred and promotes an inclusive environment where each resident matters. This involves providing a service in accordance with the stated purpose and function and the effective and efficient deployment of resources. Good communication is seen as the cornerstone on which safe and effective services are provided.

The governance and management systems in place assure the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open, fair and transparent culture that empowers the residents using the service. Overall, accountability for the delivery of residential services is clearly defined and there are clear lines of accountability at individual, team and organisational level so that all staff working in the service are aware of their responsibilities and who they are accountable to.

The governance and management arrangements should include contingency plans for any public health emergency, including the identifying the lead person and what arrangements would be in place for the continued oversight and management of the centre during absences of the person in charge or key management personnel. The governance arrangements and operational structures ensure that the provider can detect, manage and respond in a sustainable way to the risk of outbreaks. All staff, and residents where appropriate, are aware of who is in charge when the person in charge is not on duty or available.

The arrangements in place should clearly identify how HPSC, HSE and Department of Health updated advice is accessed and communicated in a timely manner and how the risk assessments and procedures to be reviewed and updated are done so in an appropriate and timely manner.

The culture within the centre encourages regular feedback from residents, relatives, staff and others, and this feedback informs practice. The service is provided in accordance with the statement of purpose, and it deploys resources effectively and efficiently.

The governance systems ensure that service delivery is safe and effective through the ongoing audit and monitoring of its performance resulting in a thorough and effective quality assurance system in place. The provider, management team and person in charge are continually looking for innovative ways to meet the evolving needs and preferences of individual residents and to ensure their rights are respected. There is evidence that they strive for excellence through consultation, research and reflective practice.

Where there is rapidly changing HSPC, HSE and Department of Health advice the provider has systems and process in place to ensure effective communication and oversight of risks and practice.

The registered provider has championed autonomy and ensures there is a clear understanding of supporting autonomy within the organisation. A policy review has been completed with the use of a supporting autonomy champion within the centre. This approach is reflected in all areas of the service, including effective resource management.

Staff are supported to effectively exercise their personal, professional and collective accountability for the provision of effective and safe care and supports. Staff are provided with access to support as well as development opportunities, and their performance is appraised at regular specified intervals by appropriately qualified and experienced staff. A written record is maintained of each supervision, support and performance appraisal, and a copy is given to the staff member. The record is signed by the supervisor and staff member at the end of each appraisal and is available for inspection. The registered provider has also put in place effective arrangements to facilitate staff to raise concerns and make protected disclosures about the effectiveness and safety of the service in accordance with legislative requirements, where relevant.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- that the centre is effectively managed,
- staff and residents know who is on charge
- if there are sufficient resources available to ensure effective delivery of care and support in line with the statement of purpose and if they are deployed efficiently, for example, are there enough staff, have residents access to necessary equipment and assistive technology and is there an appropriate and safe environment?
- if the quality and safety of care and support as outlined in the annual review is put into practice
- if there is evidence of learning and, if necessary, improvement brought about as a result of the findings of any reviews, unannounced visits and or consultation

- is there evidence that feedback from residents, relatives, staff and others has been used to inform practices
- if the organisational structure outlined in the statement of purpose is reflected in practice.

Through communication

Inspectors will communicate:

- with residents to find out if their views and experiences on the culture within the centre, the management of the centre and whether they consider there are enough resources
- with residents to establish if they have given any feedback to the service via the annual report, audits, surveys or other mechanisms; if a copy of the annual review is made available to residents; and if the six monthly unannounced visit report is made available to residents, if requested
- with the registered provider and person in charge to determine if they are knowledgeable of their responsibilities under the regulations
- with the registered provider, person in charge and staff to determine their understanding of the aims and objectives of the service and how they are implemented
- with the provider and person in charge on how they implement and monitor HPSC, HSE and Department of Health advice.
- with management and staff to establish if there is a culture of openness and whether staff know how to raise concerns about the quality and safety of the care and if they feel supported to do so
- with staff to find out they are familiar with the management structure, including their understanding of roles and responsibilities and the reporting structure
- with staff to determine their views are on the management of the service
- with staff to determine how they know who is in charge and how the centre is managed in the absence of the person in charge or other key management personnel. For example, in the event of an emergency incident and management of notifications.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the annual review (If requested, has a copy being made available to the Chief Inspector)
- written report of six monthly unannounced visits
- relevant external audits and reports
- the statement of purpose
- staff performance management/supervision records
- registrations/renewals applications and associated documentation.

Additional documents that may be reviewed:

- staff rotas
- minutes of residents and staff meetings
- the accidents and incidents register
- the complaints register
- evidence of implementation of the capacity legislation.

Compliance indicators

Indicators of compliance include:

- the management structure is clearly defined and identifies the lines of authority and accountability, specifies roles and details responsibilities for all areas of service provision and includes arrangements for a person to manage the centre during absences of the person in charge, for example during annual leave or absence due to illness.
- where there is more than one identified person participating in the management of the centre, the operational governance arrangement are clearly defined. Decisions are communicated, implemented and evaluated.
- management systems are in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored
- the person in charge demonstrates sufficient knowledge of the legislation and his/her statutory responsibilities and has complied with the regulations and or standards
- there is an annual review of the quality and safety of care and support in the designated centre
- a copy of the annual review is made available to residents
- residents and their representatives are consulted with in the completion of the annual review of the quality and safety of care
- the registered provider (or nominated person) visits the centre at least once every six months and produces a report on the safety and quality of care and support provided in the centre
- arrangements are in place to ensure staff exercise their personal and professional responsibility for the quality and safety of the services that they are delivering
- there are adequate resources to support residents achieving their individual personal plans
- the facilities and services in the centre reflect the statement of purpose
- practice is based on best practice and complies with legislative, regulatory and contractual requirements.

Indicators of substantial compliance include:

- an annual review of the quality and safety of care takes place and is used to develop the service; however, there is no written evidence of consultation with residents or their representatives

- staff are aware of the management systems and contingency plans but it is not clearly documented
- there is an annual review of quality and safety of care, but a copy is not made readily available to residents
- staff know the management structure and the reporting mechanisms but the structure is not correctly documented
- gaps are identified in the documentation but they do not result in a medium or high risk to residents using the service.

Indicators of non-compliance include:

- there are insufficient resources in the centre and the needs of residents are not met
- there are sufficient resources but they are not appropriately managed to adequately meet residents' needs
- due to a lack of resources, the delivery of care and support is not in accordance with the statement of purpose
- there is no defined management structure
- governance and management systems are not known nor clearly defined
- there are no clear lines of accountability for decision making and responsibility for the delivery of services to residents
- staff are unaware of the relevant reporting mechanisms
- there are no appropriate arrangements in place for periods when the person in charge is absence from the centre
- the person in charge is absent from the centre but no suitable arrangements have been made for his or her absence
- the person in charge is ineffective in his/her role and outcomes for residents are poor
- the centre is managed by a suitably qualified person in charge; however, there are some gaps in his/her knowledge of their responsibilities under the regulations and this has resulted in some specific requirements not been met
- the person in charge is inaccessible to residents and their families, and residents do not know who is in charge of the centre
- an annual review of the quality and safety of care in the centre does not take place
- an annual review of the quality and safety of care in the centre takes place but there is no evidence of learning from the review
- a copy of the annual review is not made available to residents and or to the Chief Inspector
- the registered provider (or nominated person) does not make an unannounced visit to the centre at least once every six months
- the registered provider (or nominated person) does not produce a report on the safety and quality of care and support provided in the centre
- effective arrangements are not in place to support, develop or manage all staff to exercise their responsibilities appropriately.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance

Green	Yellow	Orange or Red

Regulation 24	Admissions and contract for the provision of services
Standard 2.3	Each child's and adult's access to services is determined on the basis of fair and transparent criteria.

What a service striving for quality improvement looks like

Resident's right to choose where they want to live and with whom is fully respected and the organisational culture recognises that this can be stressful. The residents define what homely is to them and staff clearly recognise that this is their home. Where these choices are impacted by HPSC, HSE and Department of Health advice, residents are included and kept informed about these changes. Any impact of restrictions on these choices are kept to a minimum and for as short a duration as possible.

There is a clear planned approach to admissions and there are opportunities to visit the centre prior to admission. Consideration of admission to the centre takes into account the services outlined in the statement of purpose and residents living in the centre. Therefore, access arrangements to the centre uphold the rights of residents and do not discriminate on admission. Residents living in the centre are informed of new admissions, with due regard to the rights of the applicant for admission.

Admission to the residential service is timely, determined on the basis of fair and transparent criteria, and placements are based on written agreements with the provider. Each resident and or their representatives sign an agreement, in an accessible format, with the registered provider. If a resident or their representatives are unable or choose not to sign, this is recorded. The agreement provides for and is consistent with the residents' assessed needs, their associated personal plan and the statement of purpose.

Each resident is given the opportunity to visit the centre and meet with a staff member to discuss the process and key aspects of the service before they make a decision to stay there. In the case of emergency admissions, this is done as soon as possible after admission.

Admissions to the centre at times of a health emergency are carried out in line with HPSC, HSE and Department of Health advice where appropriate. Where HPSC, HSE and Department of Health advice impacts on normal admission practices the provider and person in charge ensure the admission policies and procedures continue to maintain and uphold individual choices as far as possible in line with any risk assessment carried out.

Evaluation of effectiveness of the admissions process and contract for the provision of services contains an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- to determine if the service as outlined in the residents' contracts is delivered in practice.
- Any HPSC, HSE and Department of Health advice is being implemented in practice

Through communication

Inspectors will communicate:

- with residents to find out their views and experiences on the admission process. For example, were they satisfied with the process and did they have an opportunity to visit the centre before moving in.
- with person in charge and staff about the admission process, including emergency admissions, if relevant.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during inspection
- the policy on the admissions, including transfers, discharge and the temporary absence of residents. Does the policy include information about how the admission procedures are impacted and arrangements in place to support adherence to HPSC, HSE and Department of Health advice.
- a sample of residents' contracts for the provision of services
- documentation that relates to the admission process to the centre such as the pre-admission assessment discharge notes
- the statement of purpose.

Additional document that may be reviewed:

- the directory of residents
- the annual review.

Compliance indicators

Indicators of compliance include:

- residents' admissions are in line with the statement of purpose

- the centre's admissions process considers the wishes, needs and safety of the individual and the safety of other residents currently living in the services
- where possible, residents and his or her family or representative have the opportunity to visit the centre
- where the usual admission procedures are affected by HPSC, HSE and Department of Health advice these are clearly documented, communicated and appropriate.
- a written contract for the provision of services is agreed on admission.

Indicators of substantial compliance include:

- while there are policies, procedures and appropriate practices in place, some gaps are evident in the maintenance of documentation that do not impact on the care or welfare of the resident
- residents have a written agreed contract but it is not signed by the resident/relative
- residents have a written agreed contract but details of some charges for additional services are not covered in the contract.

Indicators of non-compliance include:

- there are no policies and procedures for admissions in place, including transfers, discharges and the temporary absence of residents
- residents cannot visit the centre in advance of admission except where this is appropriate based on HPSC, HSE and Department of Health advice.
- residents are living in the centre even though it is unsuitable and the service cannot meet their needs
- the combination of residents in the centre is unsafe
- residents' admissions are not in line with the centre's statement of purpose
- residents admissions are not in line with HPSC, HSE and Department of Health advice and this poses a risk to other residents and staff
- not all residents have a written agreed contract in place
- residents have a written agreed contract but it does not include sufficient details of the support, care and welfare to be provided
- residents have a written agreed contract but it does not fully outline the services to be provided
- residents have a written agreed contract but it does not include the fees to be charged.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 30 Volunteers

What a service striving for quality improvement looks like

There is a clear understanding that the purpose of volunteers is to enhance the quality of life of residents and their lived experience.

The registered provider seeks out creative ways of empowering and enabling residents to participate in a meaningful way in their community. The registered provider has accomplished this by using different methods, including developing natural supports around each resident and through the ongoing development of volunteering activities and supports within member organisations.

Residents' wishes and needs are taken into consideration when volunteers are recruited. There is evidence that volunteers support residents to exercise their right to live full and active lives of their own choice.

The work of the volunteers has enhanced service delivery and quality of life of residents through developing friendships and maximising opportunities for personal growth. The role of the volunteers have also supported residents to be active citizens in their own communities, thereby achieving their full potential and living the life of their choice. The volunteering activities that take place support residents to develop new skills and promote social inclusion and community participation. Hence, residents are enabled to participate fully in the life of the society they live in.

The volunteers that support residents are fully cognisant of residents' rights.
Volunteers receive comprehensive information about their role, their responsibilities and the supervision arrangements of their work. They have access to and complete relevant training, including appropriate training on safeguarding residents.

Evaluation of the effectiveness of using volunteers consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- if volunteers receive supervision and support
- interactions between volunteers and residents. Are volunteers adhering to their roles and responsibilities?

Through communication

Inspectors will communicate:

- with residents to establish if residents have access to a volunteer and what their experience has been
- with the person in charge to establish what volunteering arrangements are in place
- with any volunteers that are available to establish their understanding of their role and responsibilities and to determine what supervision arrangements are in place.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to or during the inspection
- written descriptions of volunteer roles and responsibilities
- vetting disclosures, to determine if they are in accordance with the relevant National Vetting Bureau Act
- supervision records.

Additional documents that may be reviewed:

- residents' personal plans
- the annual review.

Compliance indicators

Indicators of compliance include:

- volunteers have their roles and responsibilities set out in writing
- volunteers receive supervision appropriate to their role and level of involvement in the centre
- volunteers provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Indicators of substantial compliance:

- volunteers have provided a vetting disclosure, have a clear understanding of their role and responsibilities, but this has not been set out in a written agreement
- gaps are identified in the documentation but they do not result in a medium or high risk to residents using the service.

Indicators of of non-compliance:

- volunteers' roles and responsibilities are not set out in writing
- volunteers have not provided a vetting disclosure
- volunteers have provided a vetting disclosure but do not receive supervision appropriate to their role and level of involvement in the centre.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 31 Notification of incidents

What a service striving for quality improvement looks like

Effective information governance arrangements are in place to ensure that the designated centre complies with notification requirements. The person in charge has ensured that incidents are notified to HIQA in the required format, within the specified timeframe and that all necessary information is submitted.

The registered provider and person in charge have developed and support a culture of openness, transparency and accountability. Incidents are appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrences. The learning from the evaluation of incident reviews is communicated promptly and used to inform the development of best practice and ultimately improve service provision. Staff are actively involved in the quality assurance programme and take responsibility for areas such as assessments and personal planning updates in response to learning from notifications. Staff have access to evidence-based research to support them in quality improvement initiatives and interventions to mitigate further episodes.

Evaluation of effectiveness of the management of notifications consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- whether residents have noticeable injuries and check that this has been recorded in the centre and reported to the Chief Inspector, where required
- any incidents that occur whilst in the centre and examine how staff respond to the incident and determine if this response was appropriate and in line with the centre's policies and procedures.

Through communication

Inspectors will communicate:

- with residents to see if they have been involved in an incident and determine their views on how incidents and accidents are managed
- with the person in charge and staff regarding the process for reporting and managing incidents and accidents
- with the person in charge to determine how she/he ensures that all incidents are recorded, notifications are made and any identified learning is used to improve the quality and safety of the service
- to establish staff understanding of incident management and whether it is in line with the regulations and the centre's policy.
- with staff to explore if they receive feedback/learning from any analysis of incidents and accidents carried out. Are there examples of where practice has improved as a

result? For example, has there been a reduction in the number of incidents as a result of any learning and subsequent change in practice?

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to or during the inspection
- the policy on incidents where a resident goes missing
- the incidents and accidents register
- records of notifications
- a sample of relevant residents' personal plans to determine if they have been updated when required following incidents and accidents.

Additional documents that may be reviewed:

- staff rotas
- medicines records
- audits relating to incidents/accidents/near misses
- minutes of residents and staff/management meetings
- the annual review.

Compliance indicators

Indicators of compliance include:

- a record of all incidents occurring in the designated centre is maintained
- a notification is provided to the Chief Inspector within 3 days of the occurrence of any incident set out in regulation 31(1) (a) to (h)
- when the cause of an unexpected death has been established, HIQA is informed of that cause
- quarterly reports are provided to the Chief Inspector to notify of any incident set out in regulation 31(3) (a) to (f)
- a report is provided to HIQA at the end of each six month period in the event of no 'three day' or 'quarterly' notifiable incidents occurring in the designated centre.

Indicators of non-compliance include:

- not all incidents and accidents are recorded in the centre
- notifications have not been submitted to the Chief Inspector
- some details recorded on the incident log do not match the information submitted to HIQA
- a system is in place to record incidents and accidents but some incidents were not reviewed when required
- some incidents were not appropriately recorded

- while there is a log of all accidents and incidents, some were not reported to HIQA within the three day time period as necessary
- when established, HIQA has not been informed of the cause of an unexpected death.

Guide for risk rating:

Compliant	Non-compliance
Green	Orange

Regulation 32 Notifications of periods when person in charge is absent

What a service striving for quality improvement looks like

Information governance arrangements are in place to ensure compliance with legislation, regulations and standards, that information is used ethically and that best available evidence is applied.

There is an effective governance structure in place where the overall accountability for the delivery of the service is clearly defined, and there are clear lines of accountability so that all staff are aware of their responsibilities and who they are accountable to at all times.

The registered provider is familiar with notification requirements and, when required, has notified the Chief Inspector of the proposed absence of the person in charge from the designated centre.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- who is in charge of the centre.

Through communication

Inspectors will communicate:

- with residents to determine if they know who is in charge of the centre
- with the registered provider to determine awareness of Regulation 32
- with staff to establish and cross check when the person in charge was absent from.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during inspection
- records of notifications
- staff rotas
- minutes of residents and staff/management meetings.

Compliance indicators

Indicators of compliance include:

- in cases where the person in charge is expected to be absent for 28 days or more, the Chief Inspector is notified one month prior to the expected absence
- in the case of an emergency absence, the Chief Inspector is notified as soon as it became apparent that the absence will be 28 days or more
- the Chief Inspector is notified within three days of the return of the person in charge.

Indicators of non-compliance include:

- the Chief Inspector has not been notified of the absence of the person in charge, as required by the regulations.
- the Chief Inspector is notified of the absence and or return of the person in charge but not within the required timeframes
- the Chief Inspector is notified of the absence of the person in charge but not all the required information has been submitted.

Guide for risk rating:

Compliant	Non-compliance
Green	orange

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

What a service striving for quality improvement looks like

Clearly defined lines of authority and accountability are essential for effective governance in order to ensure safe, quality care where the impact on outcomes for residents is positive. The service is managed by appropriately trained staff, and there is effective leadership and management that ensure appropriate delegation when necessary.

There is an effective governance structure in place where the overall accountability for the delivery of the service is clearly defined, and there are clear lines of accountability so that all staff are aware at all times of their responsibilities and who they are accountable to. There is evidence of robust systems in place to ensure staff know who is in charge in the absence of the person in charge.

The registered provider is very familiar with notification requirements and when required has notified the Chief Inspector of procedures and arrangements for periods when the person in charge is absent. The registered provider has provided the necessary assurances that the designated centre will continue to be properly managed when the person in charge is absent. The person who is responsible in the absence of the person in charge has appropriate qualifications, skills and experience to oversee the residential service and meet its stated purpose, aims and objectives.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- reporting structures in the centre and check that these are in accordance with documented arrangements.

Through communication

Inspectors will communicate:

- with the registered provider to determine awareness of Regulation 33 and to check if the registered provider is satisfied that there are appropriate arrangements in place when the person in charge is absent
- with staff to determine their understanding of the reporting structure and management arrangements in the centre when the person in charge is not present.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- notification forms
- staff rotas
- training records of the person appointed in the absence of the person in charge
- minutes of residents and staff/management meetings.

Compliance indicators

Indicators of compliance include:

- during the absence of the person in charge suitable procedures and arrangements are made for his/her absence and these arrangements have been notified to HIQA
- all required information, including arrangements regarding the running of the centre, appointment of another person in charge and the details of the person who was or will be responsible for the centre during the absence, is submitted in the notice to the Chief Inspector.

Indicators of non-compliance include:

- HIQA has not been notified of the absence of the person in charge, as required by the regulations
- the Chief Inspector has been notified of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge but this notice has not been given in writing
- the person in charge is absent from the centre and suitable arrangements have been made for his or her absence but the registered provider did not notify HIQA of the absence of the person in charge within the required timeframe
- the person in charge is absent from the centre and suitable arrangements have been made for his/her absence but the registered provider is unaware of his/her responsibility to notify HIQA of the absence.

Guide for risk rating:

Compliant	Non-compliance
Green	Orange

Regulation 34	Complaints procedure
Standard 1.7	Each child's and adult's complaints and concerns are listened to and acted upon in a timely, supportive and effective manner.

What a service striving for quality improvement looks like

The registered provider has established and implemented effective systems to address and resolve issues raised by residents or their representatives.

Staff are trained to understand resident's behaviour that indicates an issue of concern or complaint that the resident cannot communicate through other means. Such messages receive the same positive response as issues raised by other means.

Each resident is encouraged and supported to express any concerns safely and is reassured that there are no adverse consequences for raising an issue of concern, whether informally or through the formal complaints procedure. There is a culture of openness and transparency that welcomes feedback, the raising of concerns and the making of suggestions and complaints. These are seen as a valuable source of information and where necessary are used to make improvements in the service provided.

There is an effective complaints procedure that is in an accessible and appropriate format which includes access to an advocate when making a complaint or raising a concern. The procedure is consistent with relevant legislation, regulations, protocols and takes account of best practice guidelines. The procedure is used by residents and others to exercise their right to raise issues and have those issues addressed in a timely and respectful manner.

The registered provider demonstrates that the complaints procedure is monitored for effectiveness, including outcomes for residents. Management ensures that the complaints procedure is in line with best practice guidelines where confidentiality and anonymity (when required) are maintained. Information regarding complaints forms part of the quality improvement strategy of the service, identifying improvement opportunities.

Evaluation of the effectiveness of the complaints procedure consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- that there is a culture of openness that welcomes feedback and raising of concerns
- if complaints have been used to inform and improve service delivery, where applicable
- whether the complaints procedure is displayed in a prominent place in the centre
- whether the complaints procedure is in an accessible and age-appropriate format.

Through communication

Inspectors will communicate:

- with residents to explore if they know how to raise a complaint and if they feel comfortable raising a complaint
- to check if residents know how to access advocacy support and advice when providing feedback or making a complaint
- where relevant, to explore residents' views and experiences on how complaints have been dealt with in the pass and to establish if they were satisfied that the complaint was responded to appropriately and if anything changed as a result.
- with the registered provider, person in charge and staff, where necessary, to ascertain what they understand their role and responsibilities are regarding complaints and how they view and manage complaints and to establish if any complaints had led to service improvement.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the policy on the handling and investigation of complaints from any person about any aspects of service, care, support and treatment provided in, or on behalf of a designated centre
- the complaint procedure
- method for recording complaints, for example, the complaints register
- information on advocacy services.

Additional documents that may be reviewed:

- audits relating to complaints
- the statement of purpose
- the residents' guide
- minutes of residents and staff meetings
- the annual review.

Compliance indicators

Indicators of compliance include:

- the complaints process is user-friendly, accessible to all residents and displayed prominently
- there is an appeals process that is fair and objective
- residents and their families are made aware of the complaints process following admission and are also supported to understand the process and make complaints

- there is a suitable nominated person to deal with all complaints and ensure that all complaints are recorded and fully and promptly investigated
- a different nominated person is available to residents to ensure all complaints are responded to appropriately and that the records are maintained, as required
- complaints are resolved in a proactive and timely manner
- residents are made aware promptly of the outcome of any complaint
- complaints are well-managed and bring about changes when required
- any resident who has made a complaint can do so without fear of adverse consequences
- there is a culture of continuous improvement where complaints are used to plan, deliver and review services.

Indicators of substantial compliance include:

- while there are appropriate policies, procedures and practices in place, there are some gaps in the associated documentation that do not result in a medium or high risk to residents using the service
- the registered provider responds appropriately to complaints but the procedure is not written in an accessible and age-appropriate format
- each resident and their family are not made aware of the complaints process as soon as is reasonably practicable following admission.

Indicators of non-compliance include:

- there is no appeals process
- the complaints procedure is not accessible and or in an age-appropriate format
- residents are not facilitated to exercise their right to make a complaint
- residents have no access to advocacy services to assist in making a complaint
- a copy of the complaints procedure is not displayed in a prominently position in the centre
- residents do not know who to complain to as they have not been supported to understand the complaints procedure
- complaints are not investigated in a prompt manner
- staff do not know what to do in the event of a complaint being made to them
- measures required for improvement in response to a complaint are not implemented
- practice around the management of complaints is inconsistent
- residents/relatives have made complaints but have not received a response
- residents who have made a complaint are adversely affected as a result.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or Red

4.2 Guidance on regulations related to quality and safety

This section discusses regulations related to the care and support people receive and if they are of a good quality and ensure people are safe. It includes information about the care and supports that should be available for people and on the environment in which they live.

Regulation 5	Individualised assessment and personal plan
Standard 2.1	Each person has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life, in accordance with their wishes.
Standard 2.1	Each child has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life.

What a service striving for quality improvement looks like

Excellence in achieving individualised assessment and personal planning is evidenced when there is a strong and visible person-centred culture within an organisation and residents receive the care they actually need.

Individual assessment and personal planning is a process to find out about the person, their abilities and needs in order to ensure their views are respected and the support they required is planned for in an individualised way. This is a dynamic and fluid process that is constantly evaluated and updated. It is important that this process is documented in a clear and concise way that can inform continuity of care but also is seen as being owned by the resident themselves as a record of the care and supports they say they need. In order to do this, staff will need to be innovative in finding ways to support residents to express their views and live life as they choose in a way that balances risks and opportunities in a safe way. The registered provider and person in charge support staff to be creative and flexible in assisting residents to live as they choose and look beyond the options that can be offered within the boundaries of their own service. As a result, the resident's relationships within the community flourish and they have meaningful experiences that include the benefits of holding valued social roles.

The provision of individualised holistic assessment and care planning is not a separate activity carried out by one individual but part of everyday life with all staff involved, and it will result in a truly person-centred service for residents. The practice of assessment and care planning is regularly and formally reviewed and continually improved upon.

A quality personal plan cannot be created without a comprehensive and appropriate assessment. To ensure a comprehensive assessment and to develop a personal plan that is truly individualised, the person must be involved in decisions about their own care. Balancing the rights of the resident to privacy and the engagement of family in the development of a personal plan is a

complex issue, and a quality approach to the assessment and personal planning manages this issue effectively and ensures the resident's voice is prioritised and respected.

The purpose of assessing people prior to admission is to ensure that the service has the ability and facilities to support people to maintain or improve their health and well-being. A quality service ensures this assessment is carried out by the most appropriate person and that they are assured that the needs and expectations of the resident can be met. The assessment must be updated on admission to ensure it is still valid and to quickly identify any changes.

A quality personal plan is one that recognises the intrinsic value of the person by respecting their uniqueness. A rights-based approached ensures that decisions are made with the resident using the service and not for the resident. When developing a personal plan the resident's autonomy is to the fore. Residents are asked 'how would you like to spend your day', and this informs their personal planning. Promoting autonomy may require some degree of risk taking. A positive approach to risk assessment acknowledges that risk-taking is part of a fulfilled life which considers possible harms and focuses on individual strengths.

HPSC, HSE and Department of Health advice is discussed with residents and incorporated into the individual's personal plan as appropriate. These are reviewed in line with any changing HPSC, HSE and Department of Health advice.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of effectiveness of assessments and care plans form part of the continuous quality improvement cycle, and policies, procedures and practices are updated based on the finding of any review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- whether residents are provided with person-centred care and if staff practice is in accordance with residents' personal plans to ensure individual needs are being met
- residents' daily routines and determine if their needs have been appropriately assessed, if staff are meeting these needs and if residents' daily routines are person-centred or task-led (this will be done in a discrete manor)
- if the facilities and layout of the centre is suitable for the purposes of meeting the assessed needs of each resident.

Through communication

Inspectors will communicate:

- with residents to ascertain what residents' health, personal and social care needs are and whether residents are supported to have personal plans that reflect how they would like to receive their care and support
- with the residents to see if they are aware of HPSC, HSE and Department of Health advice and how they are supported to adhere to the advice.
- where possible and appropriate to do so, with the resident by sitting with the resident and going through their copy of the resident's plan with them
- with residents to elicit their views on and experience of residents on the level of involvement and support in the development, implementation and review of the resident's personal plan
- with residents, staff and the person in charge to verify how residents' personal plans are made available to the resident
- with residents, staff and the person in charge to explore whether agreed actions occur and if residents' personal plans improve the outcomes for the residents
- with staff that are directly involved in the development and or implementation of the resident's personal plan to establish what their understanding of person-centred care is, how they put it into practice and how knowledgeable they are of the residents' needs, wishes and supports
- with staff to confirm when assessments and personal plans are completed, reviewed and how they are used to inform daily care
- with the person in charge to establish what governance arrangements are in place to ensure assessments and personal plans are completed correctly and inform high-quality care.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during inspection
- the assessment and personal plan template (if a new service)
- a sample of residents' comprehensive assessments and personal plans taking into consideration observational findings and introductory meeting. Cross-check if what your observations throughout the inspection match with what is documented in the personal plan. Check that personal plans are adapted to reflect any changes in care and support required
- HPSC, HSE and Department of Health advice has been considered in the development and update of the individual personal plans where appropriate.
- a sample of daily records to verify if they correspond with inspection findings and what is documented in the resident's personal plan, where applicable
- audits and similar documents to determine if governance systems in place ensure that the resident's individual needs are regularly assessed, recorded and reviewed the complaints log relating to personal planning.

Additional documents that may be reviewed:

- the policy on admissions, including transfers, discharge and the temporary absence of residents
- any internal policies, procedures or guidelines relating to assessment and personal planning
- social care records
- resident satisfaction surveys
- audits relating to assessment and personal planning
- accidents and incidents register
- minutes of residents' meetings
- the annual review.

Compliance indicators

Indicators of compliance include:

- there is a comprehensive assessment that meets the needs of the resident and completed before the resident is admitted to the centre and is kept up to date at least annually or as required
- the comprehensive assessment used is clearly recognisable and identifies the individual health, personal and social care needs of each resident. The outcome of the assessment is used to inform an associated plan of care for the resident and this is recorded as the resident's personal plan
- Personal care plans have been reviewed and updated in line with HPSC, HSE and Department of Health advice and there is evidence of support for each residents to adhere to the appropriate advice.
- the centre is suitable for the purposes of meeting the assessed needs of each resident and, where reasonably practicable, arrangements are in place to meet these needs
- each resident has a personal plan, prepared no later than 28 days after admission to the centre, which reflects the resident's assessed needs and outlines the supports required to maximise the resident's personal development in accordance with his or her wishes, individual needs and choices
- the service works together with the resident and, with his or her consent, their representative to identify their strengths, needs and life goals. For example, in practice the personal plan is developed and reviewed with the maximum participation of each resident, and with his or her consent, their representative, in accordance with the resident's wishes, age and the nature of his or her disability
- a multidisciplinary review of the personal plan which involves assessing the effectiveness of the plan and takes into account changes in circumstances and new developments is completed annually or more frequently if required
- recommendations from the personal plan review, including any proposed changes to the plan, the reason for these changes and the names of those responsible for pursuing objectives in the plan within the agreed timescales, are recorded
- the personal plan is amended in accordance with any changes recommended following review of the personal plan
- the personal plan is made available to the resident and, with his or her consent, their representative, in an accessible format. The resident is supported to understand the plan.

Indicators of substantial compliance include:

- safe care is being delivered by staff who are very familiar with residents' care needs but aspects of the personal planning documentation does not fully reflect this appropriate care
- each resident has a personal plan that is kept under review and reflected in practice, but there are some gaps in the documentation that does not result in a medium to high risk to residents
- there were gaps in residents' personal planning documentation but care was delivered to a high standard and did not result in a medium to high risk to residents
- there is evidence of a personal plan for all residents but some residents' plans were not completed within 28 days
- the personal plan is made available to the resident and, with his or her consent, their representative, but not in an accessible format that can be easily understood by the resident.

Indicators of non-compliance include:

- a comprehensive assessment of the health, personal and social care and support needs of each resident has not been carried out
- there are no personal plans developed for some residents
- personal plans are not implemented into practice
- there are significant gaps in the residents' personal plan, and this has resulted in a negative impact on the quality of care and safety of life of the resident
- care plans conflict with HPSC, HSE and Department of Health advice and pose a risk to the residents safety
- information recorded in the personal plans has lead to conflicting care for residents
- personal plans are not specific to the resident and do not identify individual needs, choices and aspirations
- there is no link between residents' personal plans and the care and support that is delivered to them
- personal plans are not developed with the participation of each resident and or, with his or her consent, their representative
- residents' personal plans reflect residents' current needs, but there is no evidence that residents have been involved in the review of their plans and or, with his or her consent, their representative
- residents did not consent to family involvement in the development and or review of their personal plan
- residents' representatives are not informed about any significant events, incidents or accidents that affect their relative, in line with the resident's consent and as detailed in the resident's personal plan
- personal plans are not reviewed annually or more frequently, if required
- generally, residents' health, personal and social care needs are met; however, there are significant deficiencies in documentation.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 6	Healthcare
Standard 4.1	The health and development of each child and adult is promoted.
Standard 4.2	Each child and adult receives a health assessment and is given appropriate support to meet any identified need.

What a service striving for quality improvement looks like

The principles of quality healthcare are health promotion, prevention, independence and meaningful activity. Residents are supported to achieve these principles and, therefore, his or her optimal health.

The registered provider has ensured that a rights-based approach has been adopted to care delivery so that decisions are made with the resident and not for the resident. In a practical sense, this involves the resident making informed decisions about the care, support or treatment that he or she receives. The resident's ability to be autonomous and make decisions is supported and developed. Residents are supported to understand HPSC, HSE and Department of Health advice so they can make informed decisions.

The health and wellbeing of each resident is promoted and supported in a variety of ways, including through diet, nutrition, recreation, exercise and physical activities. Residents receive appropriate person-centred care and have appropriate access to a medical practitioner, such as a general practitioner (GP), of their choice, especially when their health needs change. Residents are supported to live healthily and take responsibility for their health and have their rights respected. Initiatives to promote residents' health and development are produced and delivered in accordance with the centre objectives and in consultation with residents and or families/representatives, where applicable. Management and staff are proactive in referring residents to healthcare professionals and have an excellent working partnership with them. Any service provided by a health professional creates the least disruption to the resident's life, maximise the opportunities for continuity of treatment and has taken into consideration their wishes.

Residents who are eligible, by means of their gender, age or condition, are made aware of and supported to access, if they so wish, the National Screening Services. These services include BreastCheck (for women aged 50-69 years), CervicalCheck (for women aged 25-60 years), BowelScreen (for both men and women aged 60- 69 years) and Diabetic RetinaScreen (for all persons with diabetes aged 12 years and older).

The resident's right to give consent along with those lawfully acting on their behalf has underpinned the care and treatment that is provided. Consent is obtained in accordance with Capacity Legislation. Providers have ensured that consent is obtained lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and or treatment that they are asking consent for. Consent is an important aspect of

providing care and treatment; where a resident, for example, refuses medical treatment, such refusal is recorded and the resident's GP informed.

Providing care at end of life is viewed as a privilege by the person in charge and staff. There is a high standard of end-of-life care for residents, where they experience comfort and dignity at this stage of life. There is a palliative care approach which recognises and respects the unique individuality of the resident being care for, thus providing person-centred care to the resident and those that matter most to them. Therefore, systems in place to provide effective end-of-life care are informed by a palliative care philosophy which acknowledges and addresses the quality of life of residents and their families facing the problems associated with the end–of-life stage. The prevention and relief of suffering by means of early identification, impeccable assessment and intervention are intrinsic to care delivery. Residents are cared for by highly trained staff that remain up to date with continuous professional development, are compassionate, understanding, enabling and who have specialised skills in this aspect of care. Residents and families are prepared for this stage of life. When necessary, HPSC, HSE or Department of Health advice are considered and assessed when implementing an end of life care plan to ensure the physical and emotional needs and dignity are maintained and any risk to staff, residents and visitors are assessed and mitigated. Residents and their relatives should be supported to understand any restrictions imposed due to HPSC, HSE and Department of Health guidance.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of health for each resident consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the Regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- practice to see if the residents' healthcare meets their individual needs and has regard to his or her personal plan
- if staff implement recommendations of allied health professionals and where this does not happen establish why
- how staff support residents throughout the day and how they deliver care whilst having cognisance of residents' privacy and dignity. For example, listen to the decision making process to determine if residents are actively involved and given choice and independence
- if the registered provider has supported access to allied health professionals when required by observing how effectively residents use the service. For instance, do they have adequate supports to mobilise if necessary, to enjoy their meals and during times of illness

- how staff support residents to access relevant information and education on areas such as nutrition, mental health, exercise and physical activity, sexual relationships ,sexual health, HPSC, HSE and Department of Health advice.
- if there is information in an accessible format for residents informing them of the National Screening Services, they may be eligible to avail of, and what supports the provider has in place to assist them in the decision making process.
- where appropriate to do that end-of-life care processes are implemented by staff.

Through communication

Inspectors will communicate:

- with residents to find out their views and experiences on the healthcare received and planning for the future, including end–of-life care. For example, have residents chosen their GP, are they satisfied with the GP they attend and how quickly do they see the medical practitioner? Is the access to the GP appropriate? For example was a virtual or face to face visit appropriate in the circumstances?
- with residents, staff and the person in charge to find out the level of resident involvement and support in making decisions about their care and treatment. How do residents' access allied health professionals, specialist support and equipment?
- with residents, staff and the person in charge on how they keep up-to-date with HPSC, HSE and Department of health advice and how it is implemented.
- how residents are facilitated access the National Screening Services
- to establish if any residents have exercised their right to refuse medical treatment and determine how this matter was managed
- with the person in charge and staff to ascertain what they understand about the healthcare and support that residents' need, how they ensure residents receive the best possible healthcare, and the approach adopted to end-of-life care, any training they may have received and how this is put into practice.
- With the person in charge and staff on how HSPC, HSE and Department of Health advice may impact on end of life care and what arrangements they have in place
- with the person in charge to check how residents' healthcare needs are reviewed.

Tools that can be used when communicating with resident include resident questionnaires — sections regarding care and support and rights.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- a sample of residents' personal plan regarding healthcare needs and cross check with observations that plans are being implemented in practice
- a sample of residents personal plans to determine if residents have access to National Screening Services and are assisted in the decision making process if required

- a sample of residents' admission records detailing medical, nursing and psychiatric condition, where appropriate
- a sample of residents' nursing and medical care records the resident's condition and any treatment or other intervention, where applicable
- record of a resident's refusal of medical treatment
- records of referrals and follow- up appointments.

Additional documents that may be reviewed:

- any internal policies, procedures or guidelines relating to healthcare, such as clinical policies
- medicines management records
- accidents and incidents register
- audits and surveys relating to healthcare
- the annual review.

Compliance indicators

Indicators of compliance include:

- appropriate healthcare is made available for each resident, having regard to that resident's personal plan
- a GP of the resident's choice or acceptable to the resident is made available to the resident
- where medical treatment is recommended and agreed by the resident, such treatment is facilitated
- visits to a GP or allied health professionals are supported in an appropriate way (for example, face to face or telecommunications where face to face is not possible)
- evidence to demonstrate that residents are supported to make decisions regarding the National Screening Services and are facilitated to attend if they so wish
- the resident's right to refuse medical treatment is respected and documented. Such refusal is documented and the matter brought to the attention of the resident's medical practitioner
- when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider
- residents are supported to access appropriate health information both within the residential service and available within the wider community including up to date HPSC, HSE and Department of Health advice.
- residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes
- the person in charge provides access to allied health professionals for residents. In assessing compliance with this regulation, the service level agreement, statement of purpose and residents' contracts of care should be taken into account, where applicable. Where every effort has been made by the person in charge to arrange

access to such services, then the person in charge is in compliance with the regulations.

Indicators of substantial compliance include:

- while concerted efforts have been made, not all residents have access to a GP of their choice or one that is acceptable to them or in an appropriate way
- when a resident requires services provided by allied health professionals, access to such services is not arranged in a timely manner by the provider
- most residents have access to appropriate health information but occasionally some health information relevant to specific residents is not made available
- there were some gaps evident in the maintenance of documentation but care was delivered to a high standard and did not result in a medium to high risk to residents.

Indicators of non-compliance include:

- residents do not have access to a GP
- residents are not supported to visit their GP in an appropriate way
- consent is not obtained in decision-making where necessary
- medical treatment is recommended and agreed by the resident but not facilitated
- some or all of residents' health needs were not met
- residents' personal plans were not implemented into practice
- HPSC, HSE and Department of Health advice was inappropriately implemented which has a negative impact on residents healthcare needs.
- the part of the personal plan that relates to health does not reflect the actual and or assessed needs of residents
- residents have not been supported to make decisions and are facilitated to avail of the Nation Screening Services, if they so wish,
- there is no recorded evidence that residents have been supported to make decisions and are facilitated to avail of the Nation Screening Services,
- there is insufficient or no evidence that the person in charge explored opportunities to facilitate residents access to allied health services
- there is no record of residents being referred to allied health services such as speech and language, physiotherapy and occupational therapy, where required
- residents' right to refuse medical treatment is not respected
- where residents have refused medical treatment, there is not enough evidence that this has been documented and brought to the attention of their medical practitioner
- end-of-life care does not meet the residents' assessed needs and does not take into account their expressed needs and wishes
- HPSC, HSE and Department of Health advice has been inappropriately implemented which negatively impacts on the quality of a persons end of life care.
- end-of-life care processes are in place but they are not always followed by staff
- generally, residents' healthcare needs are met; however, there are significant deficiencies in documentation.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 7	Positive behaviour support
Standard 3.2	Each child and adult experiences care that supports positive behaviour and emotional wellbeing.
Standard 3.3	Children and adults living in the residential service are not subjected to a restrictive procedure unless there is evidence that it has been assessed as being required due to a serious risk to their safety and welfare.

What a service striving for quality improvement looks like

The service recognises that behaviour is a form of communication and strives to understand and respond appropriately to the resident.

The registered provider and person in charge promote a positive approach in responding to behaviours that challenge and ensure evidence-based specialist and therapeutic interventions are implemented. Such interventions are implemented in line with the national policy and the informed consent of the resident or those acting on their behalf, and they are reviewed as part of the care planning process. Consent is obtained in accordance with Capacity Legislation. Residents are encouraged and supported to appropriately express their feelings and are helped to deal with issues that impact on their emotional wellbeing. There are clear, correct and positive communications that help residents to understand their own behaviour and how to behave in a manner that respects the rights of others and supports their development. Staff demonstrate that they have received appropriate training, are very familiar with all relevant information and have access to specialist advice and suitable support. Staff respond positively to behaviours that challenge and implement the centre policy, which is evidence based. Systems are in place to ensure regular monitoring of the approach to behavioural support and staff practices do not demonstrate institutional abuse.

Residents behavioural support needs are assessed with the resident on how they may be impacted by HPSC, HSE and Department of Health guidance. The behavioural support plans will be updated appropriately.

The registered provider promotes residents' independence and a restraint-free environment through appropriate systems which are continually reviewed. If used, restrictive procedures are based on centre and national policies and staff take the least restrictive approach. When applied, the restrictive practice is clearly documented and is subject to review by the appropriate professionals involved in the assessment and interventions with the individual. Any restrictive procedure is used for the least amount of time possible and, if required on more than one occasion, is incorporated into the resident's personal plan, with goals and timelines identified to reduce and or discontinue its use, where appropriate. This ensures that 'institutional' restraint does not happen whereby restrictions may have been put in place as a result of an incident or event and left in place with no subsequent review.

There is a clear distinction between therapeutic medicines and those used as a form of restraint. Where chemicals are used as a form of restraint, staff are very clear why such medicines are prescribed and administered.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of positive behavioural support for each resident consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the Regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- if staff actions demonstrate up-to-date knowledge and skills, appropriate to their role, in the area of behaviours that challenge. For instance, observe how staff interact with residents and, in particular, how they respond to any behaviours that challenge and what techniques they use to support residents to manage this behaviour
- if therapeutic interventions are implemented with the informed consent of the resident or representative and reviewed as part of the personal planning process
- if restrictive procedures are applied in accordance with national policy and evidence-based practice
- where a resident's behaviour requires intervention, every effort has been made to identify and alleviate the cause of this behaviour
- if alternative measures are considered before a restrictive procedure is used and the least restrictive procedure, for the shortest duration necessary is used.

Through communication

Inspectors will communicate:

- with residents to determine if residents are supported to manage their responsive behaviours. For example, are residents helped to understand their own behaviour and how to behave in a manner that is respectful of the rights of others and supports their development? Does a debriefing happen following the use of a restrictive procedure? Has implementing HPSC, HSE and Department of Health advice negatively impacted them?
- with the person in charge and staff to establish if they can demonstrate up–to-date knowledge and skills, appropriate to their role, to respond to behaviours that challenge and support residents to manage their behaviour
- with the person in charge on how behaviours that challenge are managed and monitored in the centre

- with staff to determine their understanding of policies on the provision of behaviour support and on restraint. Ask staff to explain how these policies inform their practice. Check with staff how resident's rights are supported when restrictive practices are used.
- With staff to determine if HPSC, HSE and Department of Health advice has negatively impacted on supporting residents and their behaviour.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the policy on the provision of behavioural support
- the policy on the use of restrictive procedures and physical, chemical and environmental restraint
- a sample of residents' files pertaining to the management of behaviours that challenge
- a sample of staff training records on positive behavioural support
- medicines records relating to areas such as the use of psychotropic medicines and chemical restraint.

Additional documents that may be reviewed:

- accidents and incidents reports
- audits relating to behaviours
- staff rota
- the annual review.

Compliance indicators

Indicators of compliance include:

- appropriate supports are in place for residents with behaviours that challenge or residents who are at risk from their own behaviour
- where required, therapeutic interventions are implemented with the informed consent of each resident or his or her representative and are reviewed as part of the personal planning process
- Appropriate communication and supports are in place for residents to understand any changes made which may impact them based on HPSC, HSE and Department of Health advice.
- where restrictive procedures such as physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence-based practice

- staff have up-to-date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour
- staff receive training in the management of behaviour that is challenging, including de-escalation and intervention techniques
- staff know the medicines that residents are prescribed and can differentiate between therapeutic medicines prescribed for a specific diagnosis, PRN medicines (medicines only taken as the need arises) and medicines used as chemical restraint
- where a resident's behaviour necessitates intervention, every effort is made to identify and alleviate the cause of the resident's behaviour that is challenging, all alternative measures are considered before a restrictive procedure is used and the least restrictive procedure, for the shortest duration necessary, is used
- practices observed and documentation reviewed demonstrate that, when restraint is used, it is used in accordance with current national policy as published by the Department of Health.

Indicators of substantial compliance include:

- an evidence-based policy on behavioural support is implemented into practice by a knowledgeable and skilled staff although aspects of documentation does not reflect this
- an evidence-based policy on the use of restrictive procedures and physical, chemical and environmental restraint is implemented into practice by a knowledgeable and skilled staff although aspects of documentation does not reflect this
- care interventions have been developed for the use of restrictive procedures for residents but some do not provide adequate instruction to guide staff practice
- staff implement safe and appropriate practices but the centre policy on behavioural support does not provide adequate guidance to inform staff practice
- restraint is used as a last resort and the least restrictive measure applied but the policy on the use of restrictive procedures and physical, chemical and environmental restraint does not give enough guidance to inform staff practice
- there were some gaps in documentation but care was delivered to a high standard and did not result in a medium to high risk to residents.

Indicators of non-compliance include:

- restrictive procedures have not been applied in line with the national policy on restraint and evidence-based practice
- there is insufficient review of interventions through the personal planning process
- Practices have been implemented based on HSPC, HSE and Department of Health advice without due consideration as to their impact on the resident's wellbeing
- staff have not demonstrated up–to-date knowledge and skills, appropriate to their role
- staff have not been trained in managing behaviour that is challenging
- all alternative measures are not considered before a restrictive procedure is used
- the least restrictive procedure, for the shortest duration necessary, is not used
- restrictive procedures are the sole means of managing behaviour
- restrictive procedures are used in a way that causes significant distress and upset to residents

- staff are not putting individual plans in place to manage residents behaviours that challenge
- reasons for using restrictive procedures are not clearly assessed or recorded
- the use of restrictive procedures are not monitored, supervised and reviewed
- staff carry out restrictive procedures without being trained to do so
- medicines are used routinely or intermittently as a response to behaviours that challenge without being clearly documented as restraint.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 8	Protection
Standard 3.1	Each child and adult is protected from abuse and neglect and their safety and welfare is promoted.

What a service striving for quality improvement looks like

Every individual has the right to feel protected and safe from all forms of abuse (physical, sexual, emotional, financial, institutional, neglect and discriminatory). Safeguarding is, first and foremost, about proactively protecting people. The culture espoused is one of openness, companionship and transparency where residents can raise and discuss any issues without prejudice. Staff recognise the importance for empathy and compassion and actively listen to the fears and concerns of residents. They understand and recognise that practices such as rigid routines and inadequate responses to complex needs may be institutional in nature and respond appropriately. Staff are vigilant and know the signs of possible abuse. The philosophy of care is based on the recognition of the worth of all residents using the service and that they will be helped to live in a dignified way. There is an atmosphere of friendliness, and resident's dignity, modesty and privacy is respected.

Robust policies and supporting procedures are implemented that makes sure residents are protected from all forms of abuse. Residents are protected by practices that promote their safety in relation to:

- recruitment, selection, training, assignment and supervision of staff and volunteers in accordance with the statement of purpose.
- the provision of intimate and personal support to people who require it
- the duty of each staff member to report any past or current concerns for the safety of the people living in the residential service or in any other setting
- access to an advocate or advocacy services
- private access to their representatives, family, advocates and external professionals
- robust reporting systems.

Each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Areas of vulnerability are identified and individual safeguards put in place. All information and advice given to help residents to care for and protect themselves is sensitive towards gender, ability and type of disability. The provider, person in charge and staff display a high level of understanding of the need to ensure residents are safe. There is a proper level of scrutiny and oversight to guarantee that safeguarding arrangements ensure residents' safety and welfare. All allegations of abuse are dealt with in an effective manner and there is evidence of a zero tolerance approach to abuse and unlawful discrimination.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of the protection of residents consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- how the centre's policy on the prevention, detection and response to abuse is implemented in practice
- how staff interact with residents, including the use of non-verbal feedback and terminology. Is it respectful of residents' dignity and privacy, and does it maximize their opportunities for choice and control?
- how residents and staff interact with each other
- whether staff are getting the balance right between protecting residents and enabling them to make informed choices about the risks associated with their care practices to determine if they indicate an open positive culture or if the practices are institutional in nature
- if residents are supported to access the Internet.

Through communication

Inspectors will communicate:

- with residents to determine if they have received information and advice that helps support them to care for and protect themselves
- with residents to find out if they feel safe, whether they know what keeping safe means and whether they are encouraged to raise any issues
- with residents to check if they have raised safeguarding concerns and to establish their views on the management of their concern
- with the person in charge and staff to find out how they protect residents and avoid discrimination.
- with staff to determine if they have received appropriate training and know how to put this training into practice in order to safeguard residents from abuse
- with the person in charge and staff to determine if they are aware of the policy and procedures for reporting abuse
- with the person in charge about how safeguarding practices and procedures are monitored.

Tools that could be used when communicating with resident include resident questionnaires.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the policy on the prevention, detection and response to abuse, including reporting of concerns and or allegations of abuse to statutory agencies. the policy on the provision of personal intimate care

- residents' finances
- staff training records on protection
- a sample of residents' personal plans regarding provision of personal intimate care.

Additional documents that may be reviewed:

- the accidents and incidents register
- audits relating to behaviours that challenge
- the planned staff rota
- the actual staff rota
- medicines records
- record of complaints that relate to protection
- minutes of residents and staff/management meetings that relate to protection
- the annual review.

Compliance indicators

Indicators of compliance include:

- each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection
- residents are protected from all forms of abuse
- the person in charge has initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse and takes appropriate action where a resident is harmed or suffers abuse
- where the person in charge is the subject of an incident, allegation or suspicion of abuse, the registered provider has investigated the matter or nominated a third party who is suitable to investigate the matter
- the person in charge put in place safeguarding measures to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity
- the person in charge has ensured that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse
- residents are safeguarded because staff understand their role in adult protection and are able to put appropriate procedures into practice when necessary.

Where children live in the centre:

- where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child, the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with
- staff receive training in relevant government guidance for the protection and welfare of children.

Indicators of substantial compliance include:

- the centre policy appropriately informs staff practice and care is provided to a high standard; however, some gaps are evident in the maintenance of the documentation that do not result in a medium or high risk to residents using the service.

Indicators of non-compliance include:

- residents are not protected from all forms of abuse
- safeguarding practices are poor
- residents are not treated with respect by staff and or management
- staff have very little knowledge in relation to safeguarding residents
- staff do not know what to do in the event of an allegation or suspicion of abuse
- residents do not know what to do in the event they experience abuse
- incidents, allegations and suspicions of abuse were deliberately concealed by the service
- incidents, allegations, suspicions of abuse at the centre were not appropriately investigated in accordance with the centre policy
- abuse allegations were not reported to the Garda Síochána when required
- any incidents, allegations, suspicions of abuse at the centre were not recorded
- incidents, allegations or suspicions of abuse at the centre were investigated but safeguards have not been put in place
- the registered provider and or person in charge do not know how to respond to incidents, allegations or suspicions of abuse.

Where children live in the centre:

- where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child, the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements were not complied with
- child abuse allegations were not referred to the statutory Child Protection and Welfare Service
- staff have not received training in relevant government guidance for the protection and welfare of children
- staff have no knowledge of *Children First* or their responsibilities under their guidance
- there is no designated person as required under the Children First Act (2015).

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 9	**Residents' rights**
Standard 1.1	The rights and diversity of each child and adult are respected and promoted.
Standard 1.2	The privacy and dignity of each child and adult are respected.
Standard 1.3	

	Each child exercises choice and experiences care and support in everyday life.
Standard 1.3	
	Each adult exercises choice and control in their daily life in accordance with their preferences.
Standard 1.6	
	Each child participates in decision making, has access to an advocate, and consent is obtained in accordance with legislation and current best practice guidelines.
Standard 1.6	
	Each adult makes decisions and, has access to an advocate and consent is obtained in accordance with legislation and current best practice guidelines.

What a service striving for quality improvement looks like

The culture of the organisation is one that ensures the rights of people with disabilities as enshrined in the UN Convention on the Rights of People with Disabilities and in Irish law are promoted and protected. The diversity and uniqueness of the residents are celebrated.

Residents' privacy and dignity is respected at all times, particularly in relation to personal communications. This is evident in the respectful way in which staff communicate with residents.

Residents know their rights, and the registered provider ensures that staff understand these rights and that they support residents to exercise their rights. The provider, person in charge and staff are fully cognisant that it is the residents' home and, therefore, support residents to define their service and make requests as part of the normal running of the service.

Residents are supported to make decisions about their lives in a way which maximizes their autonomy. The provider, person in charge and staff are fully aware of the Capacity Legislation and this informs practice. Each resident enjoys legal capacity on an equal basis with others in all aspects of life and each resident is supported to exercise their legal capacity. Each resident is presumed to have capacity to make their own decisions and is supported to make them. Only when all other supports have been exhausted is a decision taken on the resident's behalf. Such a decision is based on the best understanding of the resident's will and preferences and in accordance with legislative requirements. Residents receive clear information in a way they can understand when any proposed action is being considered in order to help them make informed choices and decisions. Residents are supported to understand any HPSC, HSE and Department of Health advice and adjusting their choices when required.

Each resident is listened to with care and respect by staff. Their views are taken into account in all decisions, and residents choose how to spend their day. Residents are facilitated and empowered to exercise choice and control across a range of daily activities and to have their

choices and decisions respected. Residents are encouraged and supported to direct how he or she lives on a day-to-day basis according to personal values, beliefs and preferences.

A sensible balance is made between the reasonable risks residents' want to take and their safety. Each resident is encouraged to work out a structure to their daily lives that best reflects their goals, activities and needs and are assisted in doing so, if required. Residents are consulted about and make decisions regarding the services and supports they receive, and their views are actively and regularly sought by the residential service.

Resident can access citizens' information, advocacy services or an advocate of their choice when making decisions, in accordance with their wishes. This helps guarantee that consultation with the option of support from an advocate, is the foundation for all decisions related to service provision and development. The assistance, support and representation available to residents focuses on their specific needs and rights and provides an environment in which residents can assert their rights to challenge the decisions and actions which restrict their opportunities and to obtain justice and equality in their daily lives.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of practices to support residents' rights consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- how staff and residents interact, taking account of the resident's capacity and their ability to consent
- whether language used is appropriate to the resident and not blanket terminology for everyone
- the decision-making process to see if residents are actively involved and given the freedom to exercise autonomy, choice and independence. For example, day-to-day decisions that form part of the resident's daily routine, including household tasks or activities
- whether there is a sensible balance between the choices residents make with reasonable risks they want to take and their safety
- whether residents are consulted with and participated in how the centre is run
- how residents are supported to make decisions. For instance, through one-to-one communication using the best techniques for that individual resident such as pictorials, Lámh or easy read information
- if residents have access to advocacy and information about their rights in a way they can understand
- whether residents can vote and attend religious/spiritual services if they wish

- how residents' privacy and dignity is promoted and supported. For example, whether the design, layout and facilities supports privacy and dignity and if CCTV is installed, where it is located and how it is used
- how privacy and dignity is respected in relation to care provision, communications and personal information. For example, are residents respected during personal care, do staff knock and seek permission before entering residents' bedrooms and is information about residents communicated discretely during staff handover.

Through communication

Inspectors will communicate:

- with residents to find out if they get to enjoy a way of life that enables self-determination and the opportunity to have fulfilling experiences. For example, can residents make choices about the services and supports they use and how they use them. Are different beliefs provided for and are alternative arrangements in place for those that do not wish to practice?
- with residents to determine if they can access advocacy services and information on their rights
- to check if residents are aware that CCTV is in use, where applicable
- to find out whether residents are given explanations when they need them and in a way that they understand
- with residents and staff to establish how consent is sought and how residents are involved in decision making. For example, how decisions which restrict the resident have been made
- with staff to explore how they support residents to make decisions. For example, do they respect the choices that residents made, treat residents with kindness and listen to them?
- with staff to determine how they support resident's privacy, dignity and confidentiality
- with staff about their understanding of capacity legislation and whether there are examples of where they have put this into practice.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to or during inspection
- the policy on provision of personal intimate care
- if CCTV is in used, the centre's policy on its use
- the policy on creation of, access to, retention of, maintenance of and destruction of records
- records of residents' meetings/forums
- records of advocacy arrangements/visits
- satisfaction surveys and quality assurance feedback results.

Additional documents that may be reviewed:

- resident's risk assessments and personal plans
- record of complaints
- minutes staff/management meetings
- the policy on the provision of behavioural support
- the policy on the prevention, detection and response to abuse, including reporting of concerns and or allegations of abuse to statutory agencies
- the policy on the use of restrictive procedures and physical, chemical and environmental restraint
- the annual review.

Compliance indicators

Indicators of compliance include:

- the registered provider addresses any breach of rights promptly and systemically to ensure opportunities for improvement are captured
- service planning and delivery is responsive to diversity, including disability, age, gender, sexual orientation, family and civil status, race, religious beliefs and ethnic and cultural background of each resident
- residents are consulted and participate in how the centre is planned and run
- residents are informed of the daily arrangements in the centre and how their personal information is managed
- residents have access to advocacy services and information about their rights
- staff members treat residents with dignity and respect
- personal care practices respect residents' privacy and dignity
- residents are encouraged to maintain their own privacy and dignity
- residents can have private contact with friends, family and significant others
- residents' personal communications, such as letters and phone calls, are respected
- the privacy of personal meetings and personal information in respect of each resident is respected and, therefore, kept confidential, with information given to staff and others on a need to know basis
- the centre is managed in a way that maximizes residents' capacity to exercise personal independence and choice in their daily lives, with routines, practices and facilities promoting residents' independence and preferences
- residents are facilitated to exercise their civil, political, religious rights and can make informed decisions about the management of their care as they are provided with appropriate information
- residents have opportunities similar to their peers
- residents are enabled to take reasonable risks within their day–to-day lives.

Indicators of substantial compliance include:

- residents are not provided with enough information about choices
- residents' rights are promoted in practice but appropriate information is not made available to residents about their rights

- there are some gaps in documentation but care is delivered to a high standard and did not result in a medium to high risk to residents.

Indicators of non-compliance include:

- residents do not participate in and or consent to decisions about their care and support
- residents do not receive assistance where necessary to make decisions about their care and support
- residents are not supported to exercise their rights
- residents' individual choices are not always promoted
- there is no consultation with residents
- residents have no opportunity to participate in the running of the centre
- residents' views are sought but there is no evidence that they are acted upon
- care is not provided to residents in a way that respects their privacy and dignity
- care is provided in a way that respects residents' privacy but is not consistent
- some practices are not sensitive to residents' needs and do not promote their privacy and dignity. For example, some phrases used to describe residents' needs are inappropriate and bedroom/bathroom doors are left open while residents receive personal care.
- residents are not encouraged to maintain their own privacy and dignity
- residents' personal communications are not respected
- information about residents is not communicated privately by staff
- residents are not enabled to make informed decisions about their lives
- routines, practices and facilities do not promote residents' autonomy, independence, choice
- staff do not know resident's individual preferences
- residents have no access to independent advocacy services
- residents are not facilitated to meet or have contact with family or friends in private
- the centre's information governance procedures do not protect residents' privacy
- residents do not have opportunities to be alone
- activities are task led by the routine and resources of the service rather than the resident and their support needs and wishes
- some residents have opportunities similar to their peers within services but some do not, and there is no clear reason for this difference.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 10	Communication
Standard 1.5	Each child has access to information, provided in an accessible format that takes account of their communication needs.
Standard 1.5	Each adult has access to information, provided in a format appropriate to their communication needs.

What a service striving for quality improvement looks like

Assisting or enabling residents with their communication needs ensures that they have a way to express themselves. This supports active decision-making in their lives, including their care, and promotes social inclusion.

Creative ways are used to ensure residents have accessible, tailored and inclusive methods of communication that empowers their decision-making and prevents social isolation. Residents are given information in a style that they can understand that enables them to make informed choices. Communication aids are used were necessary, including alternative and augmentative communication devices. Information is provided at the earliest opportunity and as required thereafter to enable residents to make choices and decisions. Where guidance as a result of a public health emergency impacts on the day to day life of residents and their social connections staff should work with residents to seek alternate arrangements to maintain those social connections.

There is an individualised approach to supporting residents that recognises the uniqueness of each resident. Staff know each resident's communication requirements and are flexible and adaptable with the communication strategies used. These communication strategies are based on the changing needs of the resident. In addition to providing individualised supports when necessary, there are positive, appropriate relationships formed between residents and staff that add real value to residents' lives. Staff communicate effectively with residents and are focussed on the resident when having these communications.

There is a strong culture established of staff advocating for residents that includes assistance and support to access information and to communicate with others. Residents are also facilitated and supported to access external advocates when required. Residents are continually facilitated and supported to communicate with their families and friends in a way that suits them, if desired.

As a result of staff and management communicating in plain English, residents know what to expect of services and good outcomes are promoted, which has improved residents' satisfaction and experience of care. Information is presented in a way that helps the resident understand it the first time they read or hear it. All information is in formats that are accessible and suitable to residents. This includes inspection reports, which the registered provider and staff have facilitated residents to understand. The registered provider has ensured that published guidance on communicating in plain English supports the implementation of this regulation.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of communication with each resident consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- residents' preferred methods of communication and whether staff are communicating through these methods
- if residents' personal plans regarding their communication needs and supports are implemented in practice
- how staff interact with residents throughout the day to establish if residents' communication needs have been properly assessed and whether staff support residents to effectively communicate at all times
- if staff spend sufficient time communicating with the resident in a way that meets their needs and wishes
- if there is access to a telephone and appropriate media such as television, radio and the Internet
- if residents have access to and use of assistive technology, aids and appliances, where required, and these devices are used on a consistent basis
- if residents are provided with appropriate support to use assistive technology, aids and appliances
- how staff are communicating with each other.

Through communication

Inspectors will communicate:

- with residents to establish each resident's individual communication needs and their views and experiences on the level of support they receive to meet these needs. For example, what is the residents preferred style of communication?
- with residents to determine their experience in accessing and using assistive technology/aids/appliances
- with residents to determine if they feel staff spend enough time interacting with them
- with the person in charge and staff about the systems of communication that is in place, training they have received and specialist support, for example, speech and language therapy.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the communication with residents' policy
- a sample of residents' assessments and personal plans regarding their communication needs and supports
- any reports for allied health professionals such as speech and language therapists
- communication systems such as communication passport, picture exchange communication systems, talking mats, pictures, objects of reference and electronic communicators
- staff training records
- education/training records for residents, for example, on assistive devices or the safe use of the Internet.

Additional documents that may be reviewed:

- the residents' guide
- the policy on provision of information to residents
- audits and surveys relating to communication
- the annual review.

Compliance indicators

Indicators of compliance include:

- each resident is assisted and supported at all times to communicate in accordance with their needs and wishes
- staff are aware of the different communication needs and supports of residents and ensure that these needs are met
- systems are in place to meet the diverse needs of all residents, which may include the input of allied health professionals
- individual communication requirements are documented in residents' personal plans and reflected in practice
- residents have access to appropriate forms of media, including radio, television, social media, newspapers, the Internet and information on local events
- residents are facilitated to access and use assistive technology and aids and appliances, where required, to promote the residents' full capabilities.

Indicators of substantial compliance include:

- some residents' personal plans do not reflect all the required assistive technology, aids or appliances that are effectively used by these residents
- residents can access telephone, radio and television but some appropriate forms of media are not available

- while staff are familiar with and support residents' communication needs to a high standard, some gaps are identified in the documentation that do not result in a medium or high risk to residents using the service.

Indicators of non-compliance include:

- each resident is not assisted and or supported at all times to communicate in line with their needs and wishes
- interventions to support and improve communication for individuals are not implemented
- staff are unaware of the different communication supports and needs of residents
- residents do not have essential aids and equipment that they require for communication
- residents do not have access to assistive technology, aids and appliances to promote their full capabilities
- residents are not supported to use assistive technology, aids or appliances.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or Red

Regulation 11	**Visits**

What a service striving for quality improvement looks like

Visits are facilitated and do not impact negatively on the other residents living in the service. Where residents share rooms, there are other options available to uphold the privacy of each resident.

There is an open and welcoming atmosphere which is resident centred. Family and friends are welcomed by the service and they participate in and are regularly involved in the resident's life, in accordance with the resident's wishes. Residents can receive their visitors in suitable communal facilities or a private area separate from their bedroom, if they wish.

Staff do not place restrictions on visits unless requested by the resident or for specific reasons, such as in the interests of safety including any HSPC, HSE and Department of Health advice, in adherence with a Court Order or, in the case of a child, where the family/guardian or social worker has requested the restriction.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of the visiting arrangements for each resident consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the Regulations.

Note: It is important to bear in mind that a residential care setting is a person's home and inspectors are also visitors in that home.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- visiting arrangements, including any restrictions, for example, the way in which visits facilitated, whether visitors are welcomed to the centre and if the visiting arrangements are flexible
- if there is any signage displayed restricting visits and the rationale for the restriction
- where visitors meet residents and where inspectors are directed to communicate with residents and or their representatives
- if there is suitable communal facilities and private areas available for residents to receive visitors.

Through communication

Inspectors will communicate:

- with residents to establish what residents' wishes are on receiving visits and if these wishes are being met. For instance, can residents receive visitors within the centre and what are the arrangements for visits outside the centre?
- with the person in charge and staff about visiting arrangements.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the policy on visitors
- the visitors sign in book, if available
- residents' assessments, personal plans and any other associated documentation in relation to any restrictions in place.

Additional documents that may be reviewed:

- accidents and incidents register that relate to visits
- the annual report.

Compliance indicators

Indicators of compliance include:

- residents meet with their visitors in private without any restrictions
- residents can receive visitors unless there is a risk posed, the resident has requested the restriction, a Court order requires it, or, in the case of a child, where family/guardian or social worker has requested the restriction
- residents can receive visitors in suitable communal facilities
- if required, residents can receive visitors in a suitable private area which is not the resident's bedroom.

Indicators of substantial compliance include:

- there is not enough suitable communal space for residents to receive visitors
- residents are facilitated to receive visitors but there is not enough private space for residents to use.

Indicators of non-compliance include:

- residents are prevented from meeting or having any contact with family members or friends, except where there are specific and justified reason given in the residents' personal plan
- residents are not allowed access to specific areas of their home

- systematic restriction of visiting takes place
- residents are not facilitated to receive visitors in line with their wishes, except where there are specific and justified reason given in the residents' personal.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Note: In specific circumstances, the non-compliance can be risk rated red. For example, when first identified the non-compliance can be risk rated orange. If the non-compliance is repeated then risk rating is red. Another example is where systematic restriction of visiting occurs.

Regulation 12 Personal possessions

What a service striving for quality improvement looks like

It is recognized that when a resident moves into a centre that they are possibly leaving behind a home filled with memories and possessions where they may have lived for a considerable period of time. Therefore, the registered provider and person in charge have created an environment which encourages residents, including those that are on respite, to bring in items that are dear to them and yet does not impact on the safety of the resident and other residents.

Our individuality is expressed in our clothing, and each resident has the right to wear the clothes of their choosing. Residents are encouraged and supported to make decisions about how their room is decorated if they wish to be involved in this process.

Residents' personal possessions are respected and protected. The importance of particular items of significance is recognised and, where possible, any personal belongings are retained. Residents have control over and can manage their own personal possessions, including financial affairs, their clothing and laundry in accordance with their needs and wishes. Each resident's bedroom is equipped with ample and secure storage for personal belongings and furniture. Facilities are also available for the safe storage of residents' monies and valuables.

Residents have easy access to personal monies and control their own financial affairs in accordance with their wishes. Information, advice and support on money management are made available to residents. Where residents need support to manage their financial affairs, they nominate a person to be entrusted with this responsibility. Consent is obtained in accordance with the capacity legislation. Nominated persons keep an account of all monies spent. If the nominated persons are staff members, they are accountable to the person in charge as well as the resident concerned.

Records and receipts of possessions handed over for or withdrawn from safekeeping are kept up to date.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of how residents' personal possessions are looked after and managed consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- how residents' finances are managed, for example, if there is transparent and safe practice
- how laundry is managed, for example, if there are arrangements in place to support residents to look after their laundry
- if there are secure arrangements for residents' belongings, if requested. For example, storage for residents' clothes, personal property and possessions. Review facilities with resident preferably and or staff
- how residents are facilitated to keep their belongings safe
- if staff ask for permission before entering into the residents' bedrooms
- whether residents are afforded the opportunity to lock their bedroom door.

Through communication

Inspectors will communicate:

- with residents about how their personal property and possessions, including monies, are managed. For example, can residents take in their own furniture and other items?
- with residents to establish how they keep control over their own clothes, how laundry is managed, if clothes ever goes missing, and, if so, if the clothes are returned
- with residents if they feel they have enough space for their belongings
- with the person in charge and staff to establish what measures are in place to ensure residents have access to and control over their belongings, including finances, and any supports that are in place.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during inspection
- policies on residents' personal property, personal finances and possessions
- records of residents' finances and personal property.

Additional documents that may be reviewed:

- the complaints register relating to personal possessions
- minutes of residents' meetings
- residents' satisfaction surveys
- the annual review.

Compliance indicators

Indicators of compliance include:

- residents retain access to and control over their own belongings, where possible
- residents are supported to bring in their own belongings into their rooms
- where necessary, residents are provided with support to manage their financial affairs
- residents do their own laundry if they wish
- when required, resident's linen and clothes are laundered regularly and returned to the correct resident
- there is enough space for each resident to store and maintain clothes and other possessions
- where residents have an account in a financial institution and money is paid in by the registered provider or staff, this is done with the resident's consent. The account is in the resident's name and not used by the registered provider in connection with the business of the centre.

Indicators of substantial compliance include:

- while there are appropriate policies, procedures and appropriate practices in place, there are some gaps in the documents but they do not result in a medium or high risk to residents using the service
- residents are supported to keep their own belongings but the facilities do not enable them to have full control over these belongings
- not enough storage space is provided for residents' clothing and belongings
- residents' clothes are sometimes returned to the wrong resident
- while residents have access to and control of their property and possessions, some residents have not been provided with adequate support to manage their financial affairs.

Indicators of non-compliance include:

- residents' belongings and or money regularly go missing in the centre and are not returned to the resident
- residents have no access to and retain no control of their belongings
- laundry facilities do not support residents to do their own laundry
- residents' clothes are not regularly laundered
- the resident's consent is not sought when money belonging to the resident is paid into an account held in a financial institution
- money belonging to the resident is paid into an account that is not in their name
- the resident's account in a financial institution is used by the registered provider in connection with the business of the centre.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Note: Non-compliance is first risk rated as orange but where continued non-compliance occurs the risk rating can be increased to red.

Regulation 13	General welfare and development
Standard 1.4	Each child develops and maintains relationships and links with family and the community.
Standard 1.4	Each adult develops and maintains personal relationships and links with the community in accordance with their wishes.
Standard 4.4	Educational opportunities are provided to each child to maximise their individual strengths and abilities.
Standard 4.4	Educational, training and employment opportunities are made available to each adult that promotes their strengths, abilities and individual preferences.
Standard 8.1	Information is used to plan and deliver child and adult person-centred, safe and effective residential services and support.

What a service striving for quality improvement looks like

The need for intimate emotional, physical and sexual closeness is a basic human need. Every human being benefits from the sense of closeness and mutual support that comes from having a network of relationships developed through school, work, hobbies and community activities. Experience of a variety of relationships helps residents to develop the social skills, confidence and self-esteem that underpins their ability to make, sustain and break personal relationships and to express their sexuality.

Residents are assisted to exercise their right to experience a full range of relationships, including friendships and community links, as well as personal relationships.

Residents are actively supported and encouraged to connect with family and friends and to feel included in their chosen communities. This is based on the resident's interests, identity, heritage and aspirations. The focus on 'valued role' is of the resident's choosing, and the registered provider has worked with the wider community to promote residents' participation and inclusion.

The organisational culture supports residents to effectively exercise their right to independence, social integration and participation in the life of the community. Prioritising the health and development of residents is seen as essential for growth, positive social relationships and community integration. Health, educational development, physical and cognitive attainment, social and emotional development and relationships with family and community as well as material wellbeing are all important factors.

Residents are encouraged to access appropriate health information and education both within the centre and in the local community, including information on diet and nutrition, mental health, the risks associated with smoking, alcohol and drug consumption, exercise

and physical activity, and sexual relationships and sexual health and any advice from the HPSC, HSE and Department of Health.

Residents are facilitated to have personal relationships and integrate into their communities in accordance with their wishes. The centre is proactive in identifying and facilitating initiatives for residents to participate in the wider community, develop friendships and to get involved in local social, educational and professional networks. Younger residents are encouraged to develop relationships with their peers with due regard to their age, capacity and protection. Assistive technology and communication supports are provided to facilitate contact. Each resident is supported on an individual basis and in sensitive and appropriate ways to develop and maintain intimate relationships with others in accordance with their wishes and preferences and in adherence with current legislation.

The registered provider has created a culture within the service of promoting lifelong education and supporting residents to fulfil potential through education and play. Residents are assisted in finding opportunities to enrich their lives and maximise their strengths and abilities. They are encouraged to feel valued and supported to reach their potentials. Residents receive vocational guidance with a view to assisting them in choosing an occupational opportunity suited to personal aptitude and interests.

Residents are given additional support and appropriate assistance when managing transitions such as changing school or entering a higher level of education/training. Residents approaching school-leaving age are actively encouraged and supported by the service to participate in third-level education or vocational training programmes as appropriate to their abilities, interests and aspirations. Residents are also supported to actively seek employment, where appropriate. While the regulations and standards do not make specific reference to retirement plans, in the context of providing holistic quality of life support, retirement plans should be included.

Residents are facilitated to make the best possible use of their inherent and potential capacities — physical, mental and moral — in order to allow them to achieve the fullest possible social integration and individual development. Residents can develop their capabilities and skills to the maximum and the process of social integration or reintegration is priortised. Residents are encouraged and provided with the opportunity to feel part of the wider community and have a valuable input. The registered provider has ensured that residents are successfully amalgamated into the community through proactive engagement with the community. Education is provided to the community that residents live in so that there is a fuller understanding of the importance of supporting residents to become active members in their community. All necessary safeguards are in place to protect residents against abuse from the community.

There is recognition that each resident has something to contribute at every stage of their life. This contribution is directly linked to their quality of life.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of the arrangements in place for residents' general welfare and development consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- if residents' personal plans are implemented in practice in relation to their assessed needs in areas such as activities and education requirements and wishes
- if there is access to facilities for occupation and recreation both within the centre and externally
- if residents can participate in activities that suit their interests, capacities and developmental needs.

Through communication

Inspectors will communicate:

- with residents to determine if they are supported to take part in activities that they enjoy and are meaningful to them. Are there opportunities for new experiences and social participation?
- with children to establish if they have opportunities for play and age-appropriate opportunities to be alone
- with residents to determine if they feel supported to develop and keep personal relationships. Do they have opportunity to form connections with the wider communit as they wish?
- with residents to determine whether their training, educational and employment neec and wishes are met
- with the person in charge to determine how appropriate care and support is provided in line with evidenced-based practice. How are resident's preferred interests determined?
- with staff to ascertain how they support residents to engage in the activities
- with the person in charge and staff to determine how residents can access opportunities for education, training and employment. Are there examples of where residents have attained educational goals, where applicable?

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during inspection

- the staff training and development policy
- in centres where children reside, the education policy
- the access to education, training and development policy
- assessments
- records of education and training programmes
- residents' personal plans
- social care records
- daily records.

Additional documents that may be reviewed:

- the complaints register relating to general welfare and development
- the annual review.

Compliance indicators

Indicators of compliance include:

- each resident is provided 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
- residents are provided with access to facilities for occupation and recreation
- residents are provided opportunities to participate in activities in accordance with their interests, capacities and developmental needs
- residents are provided supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes
- residents are supported to access opportunities for education, training and employment
- where residents are in transition between services, continuity of education, training and employment is maintained.

In centres where children live:

- when residents enter residential services their assessment includes appropriate education attainment targets
- residents approaching school-leaving age are supported to participate in third level education or relevant training programmes as appropriate to their abilities and interests
- each resident is provided with opportunities for play
- each resident is provided with age-appropriate opportunities to be alone
- each resident is provided with opportunities to develop life skills and help to prepare for adulthood.

Indicators of substantial compliance include:

- residents have opportunities to participate in activities but not as often as they would like
- while there are appropriate policies, procedures and appropriate practices in place, there are some gaps in the documents that do not result in a medium or high risk to residents using the service.

Indicators of non-compliance include:

- each resident is not provided 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
- residents have no access to occupation and recreation facilities
- residents have no opportunities to participate in activities
- residents have opportunities to participate in activities but not in accordance with their interests, capacities and developmental needs
- residents are not supported to develop and maintain personal relationships and links with the wider community in accordance with their wishes
- residents do not have appropriate opportunities to make friends external to the centre
- residents live in isolation in the centre with minimal involvement with the community
- individual residents are involved in the community but only as part of a group activity with other residents from the centre
- some residents have friends in the wider community but are not actively encouraged to develop and maintain friendships
- individual residents have some involvement in the wider community but are not actively encouraged to do so
- continuity of education, training and employment is not maintained for residents that transition between services.

In centres where children live:

- there is no policy that complies with relevant legislation about the education needs of residents
- there is a policy that complies with relevant legislation about the education needs of residents but staff are not sufficiently knowledgeable about it
- there is no assessment of resident's educational needs on entering the service
- residents approaching school-leaving age are not supported to participate in third-level education or relevant training programmes.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 17	Premises
Standard 2.2	The residential service is homely and accessible and promotes the privacy, dignity and safety of each child.
Standard 2.2	The residential service is homely and accessible and promotes the privacy, dignity and welfare of each adult.

What a service striving for quality improvement looks like

The residents define what homely is to them, and their home is tastefully decorated to meet their needs and wishes. The residential service has to be clean but if the residents do not wish to do certain tasks such as keeping their bedroom tidy this is respected as long as it does not pose a risk to residents. The registered provider explores opportunities to balance risk management with the homeliness of the centre and the residents' wishes for their own homely environment.

Each residential service has its own special features and layout depending on the building and the needs of the residents who live there. The design and layout of the premises ensures that each resident can enjoy living in an accessible, safe, comfortable and homely environment. This enables the promotion of independence, recreation and leisure and enables an excellent quality of life for all who live there.

The living environment is stimulating and provides opportunities for rest and recreation. The registered provider has ensured best practice in achieving and promoting accessibility. Each resident participates in choosing equipment and furniture in order to make it their home and can access appropriate professional advice in selecting equipment that facilitates functional activity and promotes independence. Appropriate and accessible indoor and outdoor recreational areas are provided in the service.

Residents have their say in the decoration of the garden. Residents can access and use the available space both within the centre and garden without restrictions.

The provider risk assess the centre in light of any HPSC, HSE and Department of Health advice and supports residents to make any changes to their environment which supports them the adhere to such advice.

The registered provider has carefully considered ways of providing a permanent home for residents. There is security of tenure for residents living in rented accommodation.

Prior to commencing any extensions to existing centres or in advance of building a new centre, the views of residents using the service and staff are sought about what works well and what they would like to see improved. Noise levels are monitored to ensure there is no negative impact on residents, especially during any renovations or extensions.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of how the premises meets each resident's needs and wishes consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- from the walk around of the centre and grounds to determine how the design and layout impacts on the residents quality of life
- if the relevant schedule requirements are met, including whether there are adequate services such as heating, lighting and ventilation
- if residents can move unimpeded around the centre, taking into account factors such as accessibility and whether any alterations have been made. Do these enhance residents' quality of life and safety?
- if the internal and external areas of the premises are secure and safe
- whether there is evidence of an ongoing maintenance programme
- the arrangements for waste disposal.

Through communication

Inspectors will communicate:

- with residents to find out their views and experiences on how the premises meets their needs and impacts on the their day-to-day life as well as the level of involvement they have in decision-making about any possible changes
- with the registered provider/person in charge to determine what measures are in place to ensure the premises meets residents' needs
- with staff and the person in charge to determine their views on the internal and external areas of the premises as to whether it is suitable for the care, treatment and support of residents and whether there are any planned changes.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- maintenance and service records and contracts.

Additional documents that may be reviewed:

- accidents and incidents register relating to the premises

- minutes of residents' meetings relating to the premises
- resident satisfaction surveys relating to the premises
- floor plans
- the statement of purpose
- audits relating to the premises
- the annual report.

Compliance indicators

Indicators of compliance include:

- the design and layout of the centre are in line with the statement of purpose
- there is adequate private and communal accommodation
- best practice is used to achieve and promote accessibility
- if needed, alterations are made to the centre to ensure it is accessible to all
- the physical environment is clean and kept in good structural and decorative repair
- the premises meets the needs of all residents and the design and layout promotes residents' safety, dignity, independence and wellbeing
- clear records of major repairs, capital works and maintenance works are kept
- residents have access to appropriate equipment which promotes their independence and comfort
- the equipment is fit for purpose and there is a process for ensuring that all equipment is properly installed, used, maintained, tested, serviced and replaced where necessary
- facilities are serviced and maintained regularly
- there is suitable heating, lighting and ventilation in the premises
- there is communal space for residents suitable for social, cultural and religious activities
- adequate space and suitable storage facilities is available for the personal use of residents
- there is a separate kitchen area with appropriate cooking facilities
- there is enough suitable and sufficient kitchen equipment to store food appropriately and complete related tasks such as dish washing
- there are enough toilets, bathrooms, showers to meet the needs of residents
- rooms are of a suitable size and layout suitable for the needs of residents
- general and clinical waste is disposed of safely
- where the centre accommodates adults and children, sleeping accommodation is provided separately and decorated in an age-appropriate manner
- there is a suitable outside areas for children to have age appropriate play and recreational facilities.

Indicators of substantial compliance include:

- an adequate number of baths, showers and toilets are available and do not pose a risk to residents; however, some of these facilities are in need of renovation but there is a plan in place for the necessary work
- some areas of the centre had not been kept in a clean condition although there were cleaning systems in place. During the inspection, staff commenced cleaning these areas and most areas were cleaned before the end of the inspection.

- storage for residents' personal belongings is available but limited
- the kitchen has suitable and sufficient cooking facilities but not enough suitable kitchen equipment and tableware
- where adults and children are accommodated, separate sleeping accommodation is provided but not decorated in an age-appropriate way.

Indicators of non-compliance include:

- the design and layout of the centre is not in line with the statement of purpose and does not meet residents' needs
- the centre is unclean and or not kept in a good state of repair
- schedule requirements are not met
- private and or communal accommodation does not meet residents' needs
- space in the bedrooms is restrictive and does not allow free movement of the resident and staff around all furniture and equipment
- there is not enough suitable storage
- there are not enough toilet and washing facilities
- general and clinical waste cannot be disposed of safely
- the kitchen does not have suitable and sufficient cooking facilities, kitchen equipment and tableware
- residents who need assistive equipment do not have it available to them. This negatively impacts on their quality of life
- equipment is not maintained in good working order
- residents are restricted in accessing areas due to the poor design of the building
- there is no review of the centre's accessibility
- required alterations to make the centre accessible to all are not carried out
- there is no suitable recreation area for children to play in outside
- where the centre accommodates adults and children, separate sleeping accommodation is not provided.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 18 Food and nutrition

What a service striving for quality improvement looks like

Eating and drinking well is viewed as an important part to play in the health and well-being of residents of all ages. Residents are encouraged to eat a varied diet and they are communicated about their meals and their food preferences. Religious and cultural requirements around food are accommodated. Residents can choose to participate in the preparation, cooking and serving of their meals.

Residents' food and nutritional needs are assessed and used to develop personal plans that are implemented into practice. There are processes in place to robustly monitor and evaluate resident's nutritional care thus ensuring provision of high quality care. All relevant staff are equipped with the appropriate level of knowledge, skills and competence to ensure the food and nutritional needs of each resident are met.

Food is appetising and served in an appropriate way to ensure that residents enjoy their food. The timing of meals and snacks throughout the day are planned to fit around the needs of the resident being supported. Each resident has plenty of time to eat and drink and mealtimes are therefore unrushed and a time of pleasant social sharing. To enhance the dining experience staff normally sit with residents they support during meals and snacks and where appropriate share the same foods and drinks.

There are clearly defined responsibilities in planning and managing food and nutritional care for residents. There is an evidence based policy on monitoring and documentation of nutritional intake that informs practice. Planned programmes of training and education take place to underpin policy, protocols and practice. Links with medical, dietetic, dental, speech and language and occupational therapy are well established.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of planning and managing food and nutritional care for residents consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- mealtimes, if appropriate to do so, in order to experience the atmosphere; determine if residents are offered choice, receive adequate food and drink and, get sufficient staff support; and establish if there are delays in staff support and assistance how this is managed

- if residents' choices are respected regarding where they dine, where they sit, who they sit with and the meal they eat
- if residents are included in the preparation of their own meals and if residents are offered regular drinks and a choice of snacks outside mealtimes
- if the dining area is appropriate and that there are enough suitable storage arrangements for foodstuffs
- if there are sufficient quantities of food and drink available
- if the policy on monitoring and documentation of nutritional intake is evident in practice
- whether arrangements for residents' specialist diets are met
- the way in which menu choices are communicated to residents. For instance, are they discussed with residents and displayed in an accessible format?

Through communication

Inspectors will communicate:

- with residents to find out their views and experiences of the food and mealtime experience, including quality of the food and drink, staff support, meeting resident's dietary needs and preferences, and how staff ensure that mealtimes are an enjoyable and sociable experience
- with staff including the chef and or those involved in catering to determine their understanding of the nutritional care, their knowledge of specialist diets and any residents at nutritional risk and establish how they are meeting residents' preferences.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the policy on monitoring and documentation of nutritional intake,
- the policy on health and safety, including food safety, of residents, staff and visitors,
- residents' assessments and personal plans
- records of allied health input such as speech and language therapy
- weight and body mass index monitoring records
- food and fluid records
- medical notes and reviews
- staff training records on areas relating to food and nutrition
- residents' feedback from any questionnaires/surveys relating to food and nutrition.

Additional documents that may be reviewed:

- complaints register relating to food and nutrition
- minutes of residents' meetings
- environmental health officer (EHO) reports
- the annual review.

Compliance indicators

Indicators of compliance include:

- there are adequate amounts of food and drink which is wholesome, nutritious, and offers choice at mealtimes
- food is available at times suitable to residents
- meals, refreshments and snacks are available at reasonable times
- sufficient numbers of trained staff are present to offer residents assistance, when necessary, in a sensitive and appropriate way
- residents are supported to buy and prepare their own meals if this is their preference and if they can do so
- the advice of dieticians and other specialists is implemented
- interventions that relate to food and nutrition are recorded in residents' personal plans and implemented by staff
- meal times are unrushed, positive and social events
- there are adequate facilities to store food hygienically.

Indicators of substantial compliance include:

- food is nutritious, varied and plentiful, but occasionally there is limited choice
- food is nutritious, varied and plentiful, but sometimes residents' preferences are not taken into consideration
- there were some gaps in documentation but food and nutritional care was delivered to a high standard and did not result in a medium to high risk to residents.

Indicators of non-compliance include:

- there are not adequate amounts of food and drink available to residents
- food and drink is not wholesome and or nutritious
- there is no choice offered to residents at mealtimes
- advice of dieticians and other specialists has not been considered, resulting in serious incidents of choking and or allergic reactions
- there are not enough trained staff to offer assistance during meals
- residents do not receive appropriate assistance
- residents are given assistance at mealtimes but it is often hurried or undignified
- residents have no access to meals/refreshments/snacks at reasonable times
- residents are prevented from buying, preparing or choosing meals as appropriate to their ability and preference
- there is inadequate storage provision for food
- staff are not responding to risk indicators such as a sudden weight loss or prolonged malnutrition
- weights are not monitored on a regular basis (in accordance with resident's needs).

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 20 Information for residents

What a service striving for quality improvement looks like

The registered provider involves residents in co-producing their guide and where this is not possible they provider seeks to incorporate the views of residents in the residents' guide.

The required information outlined in the residents' guide corresponds with other related regulations specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services and the complaints procedure.

The registered provider has ensured that the residents' guide contains quality information, which is accurate, complete, legible, relevant, reliable, timely and valid. This information is also in a format that is accessible to residents and easy to understand.

Evaluation of effectiveness of the residents' guide consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- that a copy of the residents' guide is provided to each resident.

Through communication

Inspectors will communicate:

- with residents if they have received a copy of the residents' guide
- with the person in charge and staff to determine if they are familiar with the content of the guide.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- any resident questionnaires received prior to inspection and during inspection
- residents' guide. Check that a copy of the current version of the residents' guide is available in the centre
- policy on provision of information to residents.

Additional documents that may be reviewed:

- complaints policy

- statement of purpose
- the annual review.

Compliance indicators

Indicators of compliance include:

The resident's guide contains all required information, including:

- a summary of the services and facilities provided to residents
- the terms and conditions relating to residency
- arrangements for resident involvement in the running of the centre
- how to access any inspection reports on the centre
- the procedure respecting complaints
- arrangements for visits.

Indicators of substantial compliance include:

- there is a residents' guide but there are some gaps in the information set out in the guide
- there is a residents' guide but a copy has not been made available to all residents
- while the residents' guide was not sufficient residents knew information relevant to them about living in the centre.

Indicators of non-compliance include:

- there is no residents' guide and as a result residents' do not know the service to be provided which may have a negative impact on the outcomes for residents
- the residents' guide does not contain much of the required information and therefore residents have limited information about the service and or facilities provided, and or the terms and conditions relating to residency, and or arrangements for resident involvement in the running of the centre, and or how to access any inspection reports on the centre and or the procedure respecting complaints, and or arrangements for visits
- residents have little information to inform them of the services, facilities, terms and conditions relating to residence in the centre, complaints procedure and or arrangements for visits; this lack of information may have a negative impact on the outcomes for residents
- the residents' guide has not been made available to residents.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange

Regulation 25	Temporary absence, transition and discharge of residents
Standard 2.4	Children are actively supported in the transition from childhood to adulthood and are sufficiently prepared for and involved in the transfer to adult services or independent living.
Standard 2.4	Adults are supported throughout the transition from children's services to adults' services.

What a service striving for quality improvement looks like

Resident's right to choose where they want to live and with whom is fully respected. Access arrangements to the centre uphold the rights of residents and do not discriminate on discharge. Temporary absence, transition and discharge of residents are planned and residents are supported through these processes. The centre has defined temporary absence and residents are aware of what temporary absence and discharge means. This information informs the resident's contract of care. Transitions between services provide continuity in residents' lives and meet their specific needs.

Residents living in the residential service on a long-stay basis enjoy the security of a permanent home and are not required to leave against their wishes unless there are compelling reasons for the move. Residents are only transferred to services or independent living arrangements which can meet their specific needs and does not disrupt key events in the resident's life, as reflected in the personal plan. Each resident is consulted with in advance of any move and has access to an advocate if they wish to object. The arrangements for the transition of any resident within a service or to a new service are carried out in consultation with each resident and all transitions occur in a timely manner with planned supports in place.

Where applicable, residents are helped to prepare for adulthood and have opportunities to learn life skills, to take developmentally appropriate risks and assume increasing levels of responsibility as they grow older, in line with their age, ability and stage of development. These residents are prepared for transition to adult services or independent living and any transition to adult services is carried out in consultation with the resident and his or her family. Transitions to adult services or independent living ensure continuity in education and take account of training and employment needs, where appropriate.

During times of a public health emergency the HPSC, HSE and Department of Health guidance is considered and admission, discharges and transfers to and from the center are adjusted to ensure the safety of residents and staff.

Evaluation of the effectiveness of the temporary absence, transition and discharge of residents' processes consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- how a discharge or transition takes place if one happens to occur during inspection.

Through communication

Inspectors will communicate:

- with residents to determine their views and experiences on how well their care and support is overseen when they access other services or move from children to adult services
- with the person in charge and staff to determine how they plan and manage discharges and transitions between services, for example, hospital admissions.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to or during inspection
- the policy on admissions, including transfers, discharge and the temporary absence of residents
- documentation that accompanies a resident to another service
- relevant records for residents returning from another centre, hospital or other place
- records on services and supports available for residents transitioning between services or leaving services
- the statement of purpose
- where appropriate, records of residents' training in life-skills for new living arrangements.

Additional documents that may be reviewed:

- the directory of residents
- the annual review.

Compliance indicators

Indicators of compliance include:

- planned supports are in place when residents transfer between or move to a new services
- residents are consulted when moving between services or to a new service
- where appropriate, training in the life-skills required for the new living arrangement is provided to residents to enable them to live as independently as possible
- discharges are discussed, planned for and agreed with the residents and representative if necessary

- discharges take place in a planned and safe manner
- relevant and appropriate information about the resident is transferred between services when the resident leaves or returns to the service.

Indicators of substantial compliance include:

- training in life skills that are required for the new living arrangement is provided but some residents require additional supports
- residents are safely discharged from the centre in line with statement of purpose and this was discussed with the resident but not fully in accordance with the terms and conditions of the written contract
- while there are policies, procedures and appropriate practices in place, some gaps are evident in the maintenance of documentation that do not impact on the care or welfare of the resident.

Indicators of non-compliance include:

- on transfer of residents to and from the centre, relevant information is not provided and or received
- residents are repeatedly moved in response to a crisis
- residents do not receive adequate support as they moved between or leave the service
- residents do not receive adequate information on the services and support available as they moved between or leave the service
- residents receive information on the services as they moved between or leave the service, but there are limited supports available to the resident
- training in life skills that are required for the new living arrangement is not provided when required
- life skills are taught in an infrequent and unstructured way and are not developed effectively
- residents' discharges are not based on transparent criteria and are not in line with the statement of purpose
- residents are discharged from services without consultation, planning or agreement
- the resident's voice was not taken into consideration as part of the move
- discharges are not discussed, planned for, and or agreed with the residents
- discharges take place in an unplanned and or unsafe manner
- discharges are not in accordance with the residents' assessed needs
- discharges are not in accordance with the terms and conditions of the written agreed contract for the provision of services.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 26	Risk management procedures
Standard 3.4	Adverse events and incidents are managed and reviewed in a timely manner and outcomes inform practice at all levels.

What a service striving for quality improvement looks like

The registered provider ensures the delivery of safe care whilst balancing the right of residents to take appropriate risks and fulfilling the centre's requirement to be responsive to risk. Risk management procedures take into account any HPSC, HSE and Department of Health guidance and are reviewed and updated in a timely manner in line with changing advice.

Through effective governance arrangements, the registered provider has created a culture of safe appropriate care and support in a safe environment that residents can use. This has resulted in an appropriate balance between promoting each resident's autonomy and maintaining their safety. The registered provider has a good understanding of the different levels of risk, the size and type of the service, and the individual needs of the residents in the service. Risk management and assessment is not in isolation of the assessment and personal planning process. There is clear evidence that residents are involved in their own risk assessments.

Residents have the opportunity to live a full life without undue restriction because of the way risk is managed. A risk management framework is in place for dealing with situations where safety may be compromised and supports responsible risk taking and capacity as a means of enhancing the quality of life, competence and social skills of residents. It is evident that residents' entitlement to dignity and personal development associated with risk-taking is respected. The registered provider has ensured that positive risk assessment takes place in conjunction with person-centred planning and implementation of necessary safeguards.

The registered provider is proactive in addressing any issues of safety so that residents are supported to live fulfilling lives. Staff and residents actively participate in health and safety education and training programmes. There is prompt and effective dissemination of the recommendations and learning from the management and review of adverse events and incidents. The lessons learned are used to inform the development of best practice and improve service provision.

The registered provider is in adherence with health and safety at work guidance produced by the Health and Safety Authority. A centre specific safety statement is in place that is signed by the responsible person and dated. Staff are aware of the safety statement, which is kept up to date and reviewed at least annually. Workplace hazards are appropriately controlled, including the use of chemicals at work and night work.

The safety of residents is promoted through risk assessment, learning from adverse events and the implementation of policies and procedures designed to protect residents. Evaluation of the effectiveness of the risk management procedures consists of an element of the continuous

quality improvement cycle, which in turn, forms part of the annual review to promote positive outcomes for residents.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- whether the centre looks safe and how hazards and risks are managed. For instance, how hazards are prevented/controlled while taking into consideration resident's specific needs
- if the relevant policies, the centre's hazard analysis and risk assessment system and individual risk management plans are implemented by staff
- if HSPC, HSE and Department of Health advice is implemented in an appropriate manner throughout the centre
- If good infection prevention and control measures are in place.
- whether equipment is suitable for its purpose and appropriately stored so as to prevent accidents
- staff practices to determine if there is an appropriate balance between promoting residents' autonomy and maintaining their safety. Does staff practice support responsible risk taking and capacity?
- how staff assist residents when mobilising. For example, during meals if applicable.
- Whether, when an investigation of serious incidents or adverse events identified learning, this learning has informed practice.

Through communication

Inspectors will communicate:

- with residents to explore if it is a positive experience living in the centre and whether the resident can make choices and feel in control. Is there any sense that the resident's freedom is unnecessarily restricted? Can they safely access the outdoors?
- with residents and staff to determine how risks associated with resident care and support are managed
- with staff and the person in charge to determine their understanding of risk management, how they identify hazards and deal with emergencies, including how they support people to stay safe while minimising restrictions on their freedom and in turn maximising their independence
- with staff and the person in charge to determine their understanding of each resident's rights to make decisions in their lives that may involve some degree of risk
- with the person in charge and staff to confirm if they have received training in the area of risk management, including the use of any specialist equipment.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- the policy on risk management and emergency planning
- the health and safety of residents, staff and visitors policy
- the policy on incidents where a resident goes missing
- system for recording the assessment, management and ongoing review of risk
- any individual risk management plans for specific residents
- system for responding to emergencies
- documentation to verify that transport vehicles provided by the registered provider are roadworthy, regularly serviced, insured and equipped with appropriate safety equipment
- audits relating to risk management and the premises
- the accidents and incidents register.

Additional documents that may be reviewed:

- complaints records that raised risk issues and cross reference with other documentation
- minutes of residents and staff meetings that relate to risk issues
- the annual review.

Compliance indicators

Indicators of compliance include:

- arrangements are in place to ensure risk control measures are relative to the risk identified
- any risk control measures that might have an adverse impact on resident's quality of life is considered
- the risk management policy includes all required information
- arrangements are in place for identifying, recoding, investigating and learning from serious incidents/adverse events involving residents
- there is a system in place for responding to emergencies
- there is a system in place for the assessment, management and ongoing review of emergencies
- reasonable measures are in place to prevent accidents
- vehicles used to transport residents are regularly serviced, insured, roadworthy and suitably equipped
- residents' transportation is driven by persons who are properly licensed and trained
- before commencement of any planned building works or upgrades to the premises, the works are appropriately risk assessed.

Indicators of substantial compliance include:

- while there is a risk management policy and appropriate practices in place, some gaps are evident in documentation that do not result in a medium or high risk to residents using the service
- while there is evidence that the service is safe by staff attending to general risk management and safe care is practiced, there are gaps in documentation
- there is an effective system in place for the assessment and management of risk but reviews are not ongoing.

Indicators of non-compliance include:

- there is no risk management policy and or emergency planning arrangements for the centre
- a risk management policy is in place but some hazards in the centre have not been risk assessed
- the risk management policy does not include all the required information
- there are a number of hazards which could cause injury
- there is no learning following adverse incidents to prevent reoccurrence
- there is no effective system for investigating and learning from all incidents and accidents
- vehicles used to transport residents are not roadworthy and suitably equipped
- resident's transportation is driven by persons who are not properly licensed or trained
- there is a system for responding to emergencies but staff are not familiar with how to respond
- there is no system to ensure that control measures identified from risk assessments are implemented
- risk-adverse practices inhibit residents exercising independence and autonomy
- building works and or upgrades to the premises were commenced before an appropriate risk assessment was conducted.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 27 Protection against infection

What a service striving for quality improvement looks like

The registered provider has put in place a framework to prevent or minimise the occurrence of healthcare-associated infections (HCAIs) in order to maximise the safety and quality of care delivered to each resident. There is a person-centred and multidisciplinary approach to the prevention and control of HCAIs.

There is a continuous drive to improve quality through effective management and regular performance monitoring and evaluation of the centre. Continuous quality improvement involves creating a person-centred approach to the prevention and control of HCAIs, promoting a multidisciplinary team-based approach and providing an impetus for the attainment of evidence-based best practice in the prevention and control of infections, including HCAIs.

Good infection and control practices will comply with the standard statements of the *National Standards for infection prevention and control in community services* (2018).

The key overarching elements of managing the risk of infection are
The key overarching elements of managing the risk of infection are

- Processes to identify people (service users and staff) with communicable infection (including COVID-19) before they access services/attend work or as soon as possible after they access services/attend work
- Processes to minimize the risk of spread of infection from people (service users and staff) who access services/attend for work with unrecognized infection (Standard Precautions)
- Early detection of spread of infection in the service and immediate response to limit harm

Depending on the size and complexity of the centre and following implementation of the aforementioned standards, service providers can strive towards a quality service by adapting and applying the following:

- effective governance, responsibility and oversight of infection prevention and control management
- overall responsibility is assigned for infection prevention and control in the centre
- effective communication strategy for dissemination of information
- centre- specific infection prevention and control programmes
- adaptations and management of the physical environment minimises risks
- there is a team-based approach (residents, families, care staff and medical doctors)
- the supply of appropriate personal protective equipment is available
- there is access to external specialists when necessary

- infection prevention control is a standing item on the agenda for staff meetings/health and safety meetings
- there is oversight of antimicrobial usage
- staff and residents receive education and training on infection prevention and control including but not limited to hand hygiene, cough and sneeze etiquette, correct use of personal protective equipment and other standard precautions as appropriate
- there are prevention practices, such as care of invasive medical devises
- introduction of key performance indicators for infection prevention and control
- if an outbreak occurs there are contingency plans in place which can be implemented to minimise the spread of infection, such as zoning, cohorting and increased cleaning.
- there are immunisation programmes available.

Evaluation of effectiveness of infection prevention and control practices and procedures comprises an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- staff infection control practices
- if infection prevention and control procedures are implemented in practice
- whether appropriate advisory signage for infection prevention and control, such as hand hygiene techniques, where displayed
- the storage, management and use of equipment and medical devices, for example glucometers and nebulisers
- whether the premises are clean and hygienic
- waste management, including the handling non-clinical, clinical and hazardous waste
- if there are adequate facilities and storage for laundry
- whether there are adequate facilities and materials for hand washing/sanitising and if actions required from related audits have been implemented

Through communication

Inspectors will communicate:

- with residents to get their view on matters such as the cleanliness of the centre and staff infection control practices
- with residents and visitors (where appropriate) to determine if they were made aware of any infection risks
- with residents to determine if they are educated to understand and prevent infections to themselves and others for example, in relation to good hand washing practice

- with staff to establish their understanding of their responsibilities regarding infection prevention and control, for example, in relation to laundry management, effective cleaning, food preparation and cooking, cleaning and storage of medical equipment
- with the person in charge and staff to find out if there has ever been an infectious disease outbreak and how it was managed
- with staff that perform household duties and provide support with resident personal care about their understanding of infection prevention and control
- with staff to determine if they have training appropriate to their role in infection prevention and control including outbreak management with the person in charge and staff to determine how infection risks are communicated
- with the person in charge and staff to determine what protocols are in place when a resident is re-admitted from an acute care setting.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- staff training records
- procedures that are for the prevention and control of healthcare-associated infections
- risk assessments on infection control
- educational material, for example, leaflets available for residents, relatives and staff.

Additional documents that may be reviewed:

- residents' assessments and personal plans specifically in relation to infection control
- evidence of consultation with residents in relation to prevention and management of infections
- documented cleaning programmes/schedules
- infection control audits
- written report of unannounced visits and any associated action plans
- notifications to HIQA and the and the Health Service Executive's Department of Public Health.
-

Compliance indicators

Indicators of compliance include:

- the prevention and control of HCAIs is effectively and efficiently governed and managed
- the physical environment, facilities and resources are managed to minimise the risk of residents, staff and visitors acquiring a HCAI
- human resources are effectively and efficiently managed in order to prevent and control the spread of HCAIs

- hand hygiene practices that prevent, control and reduce the risk of the spread of HCAIs are in place
- HCAI and communicable/transmissible disease outbreaks are managed and controlled in a timely, efficient and effective manner in order to reduce and control the spread of HCAIs.

Indicators of substantial compliance include:

- while it is evident that infection prevention and control practices and procedures are delivered to a high standard, some gaps are identified in the documentation that do not result in a medium or high risk to residents.

Indicators of non-compliance include:

- care plans and or risk assessments are not in place, inadequate or not being implemented in relation to infection prevention and control or the prevention of HCAI
- adequate arrangements are not in place to ensure that all staff receive mandatory hand hygiene training on induction and job/role specific training necessary to prevent HCAIs
- arrangements are not adequate to ensure the effective management of clinical/hazardous waste, linen and laundry, equipment, medical devices and environmental cleaning
- seasonal influenza vaccination has not been offered to all residents and staff and information is not given to residents to enable them decide whether to be vaccinated
- communication systems are not in place or inadequate to ensure effective communication between services in relation to residents who are colonised and or infected with a communicable transmissible organism/infection which may negatively impact other residents
- either audits do not take place or audits take place but their effectiveness is not demonstrated. For example, findings from audits are not shared with staff or remedial action is not undertaken to mitigate the risks identified.
- there have been repeated recent outbreaks of infections which are not properly managed
- hand washing/sanitising facilities are not readily accessible to staff where residents are at risk of a HCAI
- visitors to residents at risk of HCAI do not have ready access to hand washing or sanitising facilities.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Regulation 28 Fire precautions

What a service striving for quality improvement looks like

All staff have received suitable training in fire prevention and emergency procedures, building layout and escape routes, and arrangements are in place for making residents aware of the procedure to follow.

The registered provider has sought appropriate advice from a competent person when required and has applied appropriate fire safety guidance documents. The risk posed by fire is subject to ongoing risk assessment in the centre and, as a result, fire precautions that are implemented reflect current best practice as far as possible.

There are a range of appropriate fire precautions in place, including excellent housekeeping. There is evidence that the registered provider and person in charge understand the importance of housekeeping as being an integral part of an efficient fire safety regime. The registered provider has ensured that all fire equipment and building services are provided and maintained in accordance with the associated standard and by competent service personnel. Fire safety checks take place regularly and are recorded.

The registered provider is proactive in continuous quality improvement. Oversight and monitoring is carried out on a routine basis. Evaluation of the effectiveness of the fire precautions that are in place consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review, in compliance with the regulations.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- what fire safety precautions are in place, for example, fire-fighting equipment, including fire detection and alarm system, emergency lighting and fire extinguishers, and whether escape routes are kept clear of obstructions
- whether the procedures to be followed in event of fire are displayed appropriately
- whether arrangements for calling the fire service and evacuation of the centre are included and are correct
- whether signage is displayed where required, for example, illuminated emergency exit signage in larger centres
- whether signage is displayed in smaller centres (community dwelling houses), for example, illuminated emergency exit signage where the exit is not readily apparent
- whether the building is adequately subdivided with fire resistant construction such as fire doors, as appropriate
- the way in which equipment is maintained, for example, laundry and kitchen equipment such as dryers, extractors

- if there are safe smoking arrangements, for example, adequate control measures in place such as appropriate supervision by staff
- how medical gases and combustible materials are stored
- whether beddings and furnishings are made from flammable materials, especially in shared bedrooms/smoking room or if a resident smokes or has behaviour that challenges that may lead to them lighting fires.

Through communication

Inspectors will communicate:

- with residents to establish their knowledge of the centre's evacuation procedures and level of involvement in fire drills
- with the registered provider, the person in charge and or staff about the fire safety management system. For example, determine if fire precautions are reviewed for adequacy and any learning from training, drills or adverse events are integrated into fire precautions.
- with staff about training received and participation in drills to establish their level of understanding regarding the fire safety arrangements in place
- with the person in charge and staff to confirm when and how fire drills take place.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- procedures to be followed in the event of fire
- fire-fighting equipment records, including fire extinguishers, fire alarm, emergency lighting and house fire safety/housekeeping checks carried out by staff
- records of fire drills, checking that drills are used to determine if the fire procedure is fit for purpose and are used to identify training, staff and equipment needs
- staff training records on fire safety, checking if training takes places annually or more often depending on changes in working practices/processes or staff responsibilities, risk assessment and staff turnover
- risk assessments, where applicable
- assessments of the needs and capabilities of residents for evacuation.

Additional documents that may be reviewed:

- staff rosters
- audits relating to fire safety
- fire safety reports/risk assessments carried out by external competent person
- correspondence from local fire department
- building service installation and maintenance records, including electrical installation/appliances, gas installation/appliances, heating appliances, furniture and fittings
- the annual review.

Compliance indicators

Indicators of compliance include:

- suitable fire equipment is provided and serviced when required, for example, the fire alarm is serviced on a quarterly basis and fire-fighting equipment is serviced on an annual basis
- there is adequate means of escape, including emergency lighting. For example, escape routes are clear from obstruction and sufficiently wide to enable evacuation, taking account of residents' needs and evacuation methods likely to be employed
- there is a procedure for the safe evacuation of residents and staff in the event of fire prominently displayed and or readily available, as appropriate
- the mobility and cognitive understanding of residents has been adequately accounted for in the evacuation procedure
- residents are involved in fire drills whenever possible
- staff are trained annually or more frequently if required
- staff know what to do in the event of a fire
- there are fire drills at suitable intervals, usually twice yearly or more often if required
- fire records are kept which include details of fire drills, fire alarm tests, fire-fighting equipment, regular checks of escape routes, exits and fire doors
- appropriate maintenance of laundry equipment and proper ventilation of dryers
- appropriate storage of equipment such as medical gases and combustible material.

Indicators of substantial compliance include:

- while there is evidence of adequate training and fire drills and residents are aware of the procedure to follow in the event of fire, residents are not part of fire drills and training where appropriate
- staff have received fire training and are knowledgeable of fire safety arrangements but some require refresher training
- staff show enough knowledge and understanding of what to do in the event of fire; however, regular fire drills are not taking place or fire drills are not reflective of possible fire scenarios
- some new staff had not yet received fire safety training but there is adequate supervision in place for these staff members
- while there are adequate policies, procedures and appropriate practices in place, there are some gaps in how the documents are maintained that do not result in a medium or high risk to residents using the service
- maintenance records for fire safety equipment are incomplete although all equipment appears free from fault and is fully functional.

Indicators of non-compliance include:

- the evacuation procedure for the centre is not fit for purpose, for example, the procedure includes residents remaining in their bedroom to await rescue by the fire service
- the mobility and cognitive understanding of residents has not been considered in the fire and evacuation procedure
- residents do not know what to do in the event of a fire taking into account their abilities
- escape routes are obstructed or not suitable for the residents, staff and visitors expected to use them
- there are no records of regular fire drills, fire alarm tests or maintenance of equipment
- fire safety equipment has not been serviced in the previous 12 months
- some fire doors are wedged open
- the building is not adequately subdivided with fire resistant construction such as fire doors as appropriate
- poor housekeeping and or inappropriate storage or use of medical gases and combustible materials, represents an unnecessary risk of fire in the centre
- an adequate fire alarm has not been provided
- an adequate emergency lighting system has not been provided
- staff do not know what to do in the event of a fire
- staff are not trained in fire safety and or, if required for evacuation, resident-handling
- fire evacuation procedures are not prominently displayed throughout the building, as appropriate.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or Red

Regulation 29	Medicines and pharmaceutical services
Standard 4.3	Each child's and adult's health and wellbeing is supported by the residential service's policies and procedures for medication management.

What a service striving for quality improvement looks like

Residents have appropriate control of their own medicines and staff only step in were the resident no longer has the capability to do so. The assessment on self-administration is about whether the staff need to administer resident's medicines and or provide support. The registered provider and person in charge ensure that residents receive effective and safe support to manage their medicines when such assistance is required. They also ensure that staff are competent to administer medicines. Policies and procedures outlining the parameters of the assistance that can be provided are in place to support this.

Medicines are used in designated centres for their therapeutic benefits and to support and improve resident's health and wellbeing. Medicines management, monitoring and review as part of a quality use-of-medicines approach has reduced medicine related incidents, adverse events and prevented inappropriate prescribing among residents who are at risk due to factors such as polypharmacy, the nature of their illness, co-morbidities, the characteristics of the medicines they are prescribed and the complexity of their medicines regime.

Medicines are prescribed by a registered prescriber, and, where complementary and alternative medicines are given, this is done so in a safe and effective manner. Each resident's medicines is administered and monitored according to best practice as individually and clinically indicated to increase the quality of the resident's life. Any allergies that a resident may have are also documented on all relevant records. Staff actively promote each resident's understanding of their medicines and health needs. Each resident regardless of their capacity or cognitive ability, receive accessible information in relation to their medicines.

Where residents receive medicines as a form of restraint, this is clearly documented and the effectiveness of using such medicines is closely monitored. There is a clear distinction between therapeutic medicines and those used as a form of restraint. Where chemicals are used as a form of restraint, staff are very clear why such medicines are prescribed and administered.

Residents receive a comprehensive individualised service from their pharmacist who facilitates the safe and timely supply of medicines, as well as information and pharmaceutical care to ensure the best possible outcome for each resident living in the centre. Each resident is afforded the opportunity to consult with their pharmacist and or GP about medicines prescribed in line with their wishes. There are also systems in place to support out-of-hours access to the GP and pharmacist.

All medicines errors, suspected adverse reactions and incidents are recorded, reported and analyzed within an open culture of reporting. Learning is fed back to improve each resident's safety and to prevent reoccurrence.

Evaluation of the effectiveness of medicines management consists of an element of the continuous quality improvement cycle, which in turn, forms part of the annual review.

Examples of information/evidence that will be reviewed and how this will be done

Through observation

Inspectors will observe:

- that policies and procedures on medicines management are reflected in practice
- that residents are offered choice in relation to their pharmacist and how medicines are managed, for example, residents' can choose to self administer with or without support from staff
- who can access medicines and whether they are secure and safe from unauthorized access
- the procedure for key holding. For example, staff who are in possession of keys are trained in medicines management, keys for medicines are not part of the general master key system and keys are stored securely when the centre is not open. Staff clearly understand the responsibility of being the key holder.
- that medicines are appropriately stored, including current medicines, medicines that need refrigeration, out-of-date/discontinued medicines and controlled drugs. For example, current medicines may be stored in the resident's bedroom especially if the resident looks after and self administers their medicines.
- to determine that the method of disposal of such medicines is in line with legislation and guidelines
- a medicines round, in a discreet manner — some centres have adopted the 'do not disturb' lanyards, which needs to be taken into account when observing medication rounds
- to establish if the 10 rights of medicines administration are followed. Do residents receive their medicines safely and at the correct time?

Through communication

Inspectors will communicate:

- with residents to find out if they are satisfied that their medicines are managed appropriately. For example, are they administered on time and has it been explained what they are for?
- with residents, staff and person in charge to determine if residents are supported to self-medicate and how this is managed
- with the staff and person in charge involved in the management and administration of medicines to determine what they understand to be safe medicines management and

to determine their training/competencies and their knowledge of resident's individual needs
- with staff that administer medicines and or provide medicine support to residents to determine their understanding of medicines that are used, including possible side effects.

Through a review of documents during preparation or onsite activity

Inspectors will review documents such as:

- resident questionnaires received prior to and during the inspection
- policies and procedures on medicines management, including on controlled drugs if appropriate
- medical and medicines related records maintained
- admission/discharge records
- ordering, delivery and receipt process records
- prescriptions and medication administration records
- risk assessments and arrangements on self-administration
- residents' personal plans, checking, for example, where a resident self administers if the level of support and resulting responsibility of the staff is documented
- medicines reconciliation records
- temperature records for medicines that require refrigeration
- record for the disposal of medicines
- any special arrangements in place for high alert medicines such as warfarin, insulin, methotrexate and digoxin
- medicine audits and reviews
- staff training records and competency assessments.

Additional documents that may be reviewed:

- staff rotas
- staff performance appraisals
- the annual review.

Compliance indicators

Indicators of compliance include:

- each resident has a choice of pharmacist or one who is acceptable to them
- every effort has been made to offer a choice of pharmacist or provide one acceptable to the resident
- residents are provided support in their dealings with the pharmacist
- pharmacists are facilitated to meet their obligations to residents
- records of medicine-related interventions by the pharmacist are kept in a safe and accessible place

- practice relating to the ordering; receipt; prescribing; storing; including medicinal refrigeration; disposal; and administration of medicines is appropriate
- the processes in place for the handling of medicines, including controlled drugs, are safe and in accordance with current legislation and guidelines
- medicines are administered as prescribed
- medicines are administered to the resident for whom they are prescribed
- there are appropriate procedures for the handling and disposal of unused and out-of-date medicines, including controlled drugs
- residents have responsibility for their own medicines following appropriate assessments and in accordance with their wishes, preferences and nature of their disability
- safe medicines management practices are reviewed and monitored
- all alternative measures are considered before the use of chemical restraint
- where chemical restraint is assessed as being required, the least restrictive procedure for the shortest duration is used

Indicators of substantial compliance include:

- where possible a pharmacist of the resident's choice or one acceptable to them had not been made available
- the person in charge does not provide enough support to residents in their dealings with the pharmacist, if required.

Indicators of non-compliance include:

- pharmacists are not facilitated to meet their obligations to residents
- records of medicines related interventions provided by a pharmacist were not kept in a safe and accessible place
- practice relating to the ordering; receipt; prescribing; storing, including medicinal refrigeration; disposal; and administration of medicines is not appropriate
- medicines are not administered as prescribed or to the resident for whom they are prescribed
- medicines are not administered in accordance with advice provided by the pharmacist
- medicines are crushed without individual authorisation from the prescriber
- medicines being used as part of the therapeutic response to behaviour that challenges, are not reviewed regularly to ensure that it continues to meet the needs of the residents
- restrictive procedures are the sole means of managing behaviour that challenges
- out-of-date medicines or medicines for return are not appropriately managed in line with relevant national legislation or guidance
- the storage and disposal of out-of-date or unused controlled drugs is not in line with relevant regulations
- where residents self-medicate, there is no evidence that appropriate assessments have been carried out in relation to their capacity

- residents are not supported to manage their own medicines in line with their wishes and or preferences and or nature of their disability
- residents who self-medicate are not provided with secure storage for their medicines.

Guide for risk rating:

Compliant	Substantial compliance	Non-compliance
Green	Yellow	Orange or red

Appendix 1 — Related regulations

Capacity and capability dimension	
Primary regulation	**Related regulations**
Regulation 3: Statement of purpose	Regulations 5, 6, 7, 8, 9, 10, 11, 14, 15, 17, 20, 21, 23, 24, 28, 34
Regulation 4: Written policies and procedures	Regulations 3, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 23, 24, 25, 26, 27, 29, 34
Regulation 14: Person in charge	Regulations 3, 5, 15, 16, 21, 23, 31, 32, 33
Regulation 15: Staffing	Regulations 5, 7, 8, 10, 14, 16, 18, 21, 23
Regulation 16: Training and staff development	Regulations 5, 7, 8, 10, 15, 18, 21, 23, 26, 29
Regulation 19: Directory of residents	Regulations 21, 23, 24, 25
Regulation 21: Records	Regulations 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 23, 24, 25, 26, 28, 29, 30, 31, 34
Regulation 22: Insurance	Regulations 5, 7, 12, 23, 26, 31
Regulation 23: Governance and management	All regulations
Regulation 24: Admissions and contract for the provision of services	Regulations 3, 4, 5, 19, 21, 23, 25
Regulation 30: Volunteers	Regulations 4, 8, 9, 21, 23,
Regulation 31: Notification of incidents	Regulations 5, 6, 7, 8, 21, 23, 26
Regulation 32: Notifications of periods when person in charge is absent	Regulations 14, 23, 33
Regulation 33: Notifications of procedures and arrangements for periods when person in charge is absent	Regulations 14, 23, 32
Regulation 34: Complaints procedure	Regulations 3, 4, 9, 20, 21, 23
Quality and safety dimension	
Primary regulation being reviewed	**Possible related regulations**
Regulation 5: Individualised assessment and personal plan	Regulations 3, 4, 6, 7, 8, 9, 10, 12, 13, 15, 18, 21, 23, 24, 25, 26, 29
Regulation 6: Healthcare	Regulations 5, 7, 8, 9, 10, 13, 18, 21, 29
Regulation 7: Positive behaviour support	Regulations 4, 5, 6, 8, 9, 10, 16, 21, 23, 25, 29
Regulation 8: Protection	Regulations 4, 5, 6, 7, 8, 9, 10, 15, 16, 18, 21, 25, 29, 34

Regulation 9: Residents' rights	Regulations 5, 6, 8, 10, 18, 21, 23, 25, 29, 34
Regulation 10: Communication	Regulations 4, 5, 6, 7, 8, 9, 18, 21, 25, 29
Regulation 11: Visits	Regulations 4, 5, 6, 8, 9, 10, 17, 21, 25
Regulation 12 Personal possessions	Regulations 4, 8, 9, 17, 21, 28
Regulation 13: General welfare and development	Regulations 4, 5, 6, 9, 10, 17, 25
Regulation 17: Premises	Regulations 3, 4, 9, 10, 11, 12, 21, 22, 26, 27, 28
Regulation 18: Food and nutrition	Regulations 4, 6, 8, 9, 10, 21, 29
Regulation 20: Information for residents	Regulations 3, 4, 6, 21, 23, 34
Regulation 25: Temporary absence, transition and discharge of residents	Regulations 3, 4, 5, 19, 21, 23, 24
Regulation 26: Risk management procedures	Regulations 3, 4, 5, 8, 9, 10, 17, 21, 22, 27, 28
Regulation 27: Protection against infection	Regulations 4, 5, 6, 10, 11, 12, 13, 16, 17, 18, 23, 25, 26, 31
Regulation 28: Fire precautions	Regulations 3, 4, 5, 9, 17, 21, 23, 26, 27
Regulation 29: Medicines and pharmaceutical services	Regulations 4, 5, 6, 7, 8, 10, 16, 21, 23, 25, 26

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  - Assisted Decision-Making (Capacity) Act 2015
  - Child Care Act 1991

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Unit 1301, City Gate,
Mahon,