Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Avalon House
Name of provider:	Health Service Executive
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	07 October 2021 and 08 October 2021
Centre ID:	OSV-0003694
Fieldwork ID:	MON-0031727

About the designated centre

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

This designated centre provides 24 hours full-time residential care and accommodates seven adults both male and female over the age of eighteen with an intellectual disability. The centre is a large detached bungalow a few kilometres outside the nearest town. The centre comprises fifteen rooms including two small storage rooms and a lobby area. There is a kitchen, dining room, sitting room, utility room and seven bedrooms, all with en-suite facilities. There is one separate bathroom and one wheelchair accessible toilet. The centre has a large garden and patio area at the back of the house. It has its own transport; a wheelchair accessible vehicle and a people carrier. The person in charge works full-time in this centre and the staff team includes both nurses health care assistants. Staff provide support to residents during the day and at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 October 2021	08:00hrs to 16:00hrs	Julie Pryce	Lead
Friday 8 October 2021	11:00hrs to 16:00hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

On arrival at the centre the inspector observed some residents going about their morning routine, and that the atmosphere was relaxed and pleasant. Residents were being supported by staff who were familiar to them, and there were various conversations going on. The centre was spacious and nicely presented, with various communal areas arranged to meet the needs of residents. There was an area set aside as a 'salon' for hair and beauty treatments, and one of the residents was being assisted by staff in getting ready for the day in this area, with particular attention being paid to their preferred hair dressing style.

One of the residents greeted the inspector and chatted about their forthcoming day. They told the inspector what they had chosen to do, and said that they had changed their mind about the planned activities, and had chosen to do something else. They offered to show the inspector their bedroom and some of their personal possessions. Their bedroom was personal to them, and filled with their possessions including photos, clothes and shoes, all arranged as they had chosen.

The designated centre was a large and spacious home, with a large functional outside area. Each resident had their own bedroom, and where residents invited the inspector to visit their rooms, these were comfortable and nicely decorated, and individualised and personal to the resident.

Other residents were at different stages of their morning. Some residents were enjoying breakfast, and their personal preferences about how their meals should take place were clearly respected. There was chat and banter between staff and residents over the meal. The inspector observed a conversation between staff and a resident about their choice as to who would assist them with personal care following breakfast.

Another resident had a chat with the inspector and explained that they had decided to stay at home for the day. This choice was respected by staff, and when the resident changed their mind later their decision was accommodated. During the discussion the resident told the inspector that they chose their own meals. The inspector also observed that staff spoke with the resident in a respectful and compassionate manner.

Staff were observed to communicate effectively with residents throughout the inspection. It was clear that staff were well known to residents, and were familiar with strategies to ensure that residents both understood information, and had their voices heard.

The inspector met some family members of residents, and for the most part their feedback was positive. A family member said that their relative was blessed to have a home in the centre, and that there was a high level of care and support provided.

However, family members also raised some issues which had formed a complaint, and this informed part of the inspection process. It was clear that staff and person in charge had taken the complaint seriously, and whilst not concluded to the entire satisfaction of the complainant, had been addressed within the policies of the organisation. The issues raised regarding this complaint are discussed in the next part of the report.

While the inspector observed that residents were being supported to have a meaningful life there were also ongoing and prolonged compatibility issues between them. This had resulted in the delivery of ineffective and inconsistent services to some of the residents. These issues had been identified by HIQA in an inspection 12 months previously, but had not been adequately addressed. There were suggested plans to address the incompatibility amongst, but these had not yet been implemented. Residents were still experiencing discomfort and disturbance, and measures taken to mitigate the behaviour of the some residents did not always respect their rights.

In summary, the inspector found while residents were supported to have a good quality of life for the most part, residents' safety and comfort was not always maintained. In turn, this led to a number of non-compliances with the regulations arising from this inspection.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

There was a clear management structure in place with clear lines of accountability. However, the governance and management systems in place were not always effective in ensuring residents were safe and provided with a good quality of life. Additionally, the supernumerary status of the person in charge was compromised, as they were frequently required to cover absences of nursing staff.

An annual review of the care and support of residents had been undertaken, and there had been six monthly visits unannounced visits to the centre on behalf of the provider. While all required actions identified during these processes had been completed, they had not identified the findings of this inspection. A review of audits undertaken by the inspector found that they were insufficient to inform improvements. There was no consistency in audits undertaken, they did not comply with the organisation's policies and, there was little or no evidence of required actions being implemented. In turn, the system of auditing was found to be ineffective.

The staff on duty on the day of the inspection were all familiar to residents and, demonstrated a clear knowledge of the needs of residents, the supports they

required and their ways of communicating. However, there was no clear rationale for the numbers of staff on duty, and on the days when numbers were lower, staff reported this resulted in reduced outcomes for residents. In addition, there was a requirement for a nurse to be on duty at all times as two residents had been identified as needing nursing support at all times. On multiple occasions where there was only one staff nurse on duty, the person in charge, who was also a nurse, stood in for this shortage.

The person in charge had undertaken to address some staffing issues and there was documentation to show improvements in some areas, such as the planning and management of activities. However, the person in charge did not have clear oversight of staff training. Some Information relating to training records was available, and the person in charge supplied further information to the inspector in the days following the inspection. As this information was not readily available, the person in charge did nt demonstrate effective oversight of the training needs of staff.

Throughout the inspection documentation was not readily available, and was difficult to retrieve from a chaotic and disorganised filing system. Documents were frequently undated, incomplete or unsigned, and significant time was taken up in searching for required documents.

There was however, a clear complaints procedure in place,and residents and their families knew who to approach if they had a problem or a complaint. Records were kept of any complaints, and steps taken to resolve any issues. Where a complainant was not satisfied with the outcome of the complaint, records were maintained of all the steps taken, and the rationale for decisions.

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified.

Judgment: Compliant

Regulation 15: Staffing

Staffing numbers were not based on the assessed needs of residents on all occasions. The standard roster comprised two staff nurses, four health care assistants and the person in charge each day. However there were frequently only three health are assistants, and repeatedly the person in charge had to cover for the absence of a staff nurse. There was no rationale for lower staff numbers on some days other than availability of personnel.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training was up to date, however the lack of availability of documentation meant that there was no clear oversight of training needs.

Staff supervisions were not up to date, some that were due in March 2021 had not been undertaken.

Judgment: Substantially compliant

Regulation 21: Records

Records required under Schedule 3 of the regulations in relation to each resident were not readily available for inspection as required due to the chaotic nature of documentation storage in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The person in charge was frequently required to cover absences of nursing staff, which took her away from the required role of person in charge.

There was not an adequate system of audit in place. While some audits had been conducted on a weekly and monthly basis, they were not sufficiently consistent as to adhere to the organisation's policies and had not highlighted some of the failings identified during the inspection.

Where staff performance management or investigations were required, these were prolonged and not completed In a timely manner, in one instance an investigation has not been concluded in 18 months.

Judgment: Not compliant

Regulation 31: Notification of incidents

All required notifications were made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure which was available in an accessible version and clearly displayed. Residents and their representatives were aware of this procedure.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Quality and safety

Residents were not all being supported to have a meaningful life in the centre. There was ongoing compatibility issues between them which were leading to an inappropriate and unsafe service for some residents. Although the provider was aware of these issues, and some attempts to resolve the matter had been taken, appropriate or adequate actions to address these concerns had not been implemented. Significant improvements were also required with regard to personal plans, the management of behaviours of concern, documentation and residents' rights.

Residents were observed to be receiving appropriate care and support on the day of the inspection, however it was unclear that the care provided was always individualised and focused on their assessed needs.

The inspector reviewed personal plans and found that there were significant improvements required. There was insufficient evidence of any detailed individualised assessments of needs for some residents. The lack of assessment resulted in inadequate plans of care, both in terms of social care and health care. Social care goals set for residents were not always relevant, and there was insufficient evidence that these were monitored or reviewed. Information relating to learning about residents' needs was not documented or reviewed. Most of the

personal plans included goals for residents, but there was insufficient evidence that some of these were relevant.

Residents had access to appropriate healthcare, and their were records of the involvement of various healthcare professionals. Health screening had been offered and provide, and clear rational for decisions relating to screening were in place. However, not all healthcare needs were addressed, for example where a resident required consistent hydration to manage a condition and prevent recurrence of illness, fluid intake was not monitored.

Where residents required support with behaviours of concern, there were detailed behaviour support plans in place, and staff demonstrated detailed knowledge of the strategies required. Some of these had been effective in reducing the number of incidents. Incidents were recorded, in accident and incident forms where there was an impact on other residents, and in the daily notes kept by staff each shift otherwise. It was clear from these records, and from discussion with staff that there was a significant improvement, however on multiple occasions this was being managed by the use of 'as required' (P.R.N.) medication. The inspector was informed that this medication was used to minimise the disturbance to other residents, would not be required on the majority of occasions if alternative arrangements were in place.

Incidents of behaviours of concern were monitored for all residents, however required actions to minimise harm resulting from incidents was not always implemented, and the learning from incidents was not always included in personal plans.

Robust infection control systems and processes were in place. Significant work had taken place to ensure that residents' choices in relation to vaccination were supported. There was a contingency plan in place to manage any outbreak of infectious disease which was detailed and regularly reviewed. Audits and checklists in this area had been completed, and there were risk assessments in place both for the centre and for each individual residents.

There was a management system in place for the oversight of risks throughout the centre, but this was not always adequate. There was an up to date risk management policy in place, and a risk register was maintained. However a serious risk to a resident due to behaviour of concern while in vehicles had been identified, but not addressed, and there were insufficient control measures in place to manage the risk.

Fire safety measures were in place throughout the centre. Fire equipment including self-closing fire doors were in place and regularly maintained. Regular fire drills had been undertaken, and resident were able to describe the actions they would be required to take in the event of an emergency.

Whilst residents' rights were upheld to a large degree, and residents had choices in many aspects of their daily lives, residents were not all compatible with living each other. Where one of the residents posed a risk to others, this had not been fully mitigated, and the steps taken to ensure the safety of others posed a significant

infringement of the rights of the resident, who was been given medication to manage behaviours of concern. This medication was reported as only being necessary to safeguard others on many occasions.

Notwithstanding, choice was readily available to residents in decisions about their daily lives, including activities, meals and outings. Residents had been supported to go on holidays or short breaks, in particular since some of the public health restrictions had been lifted.

Regulation 10: Communication

Residents were supported in communication so that their voices were heard, and that information was available to them.

Judgment: Compliant

Regulation 11: Visits

Visits were facilitated and welcomed in accordance with residents' preferences, and had been managed throughout the public health crisis in accordance with public health guidelines.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to meet the needs of residents. There were sufficient communal and personal spaces.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk register in place including risk ratings, and a detailed risk assessment for each risk identified. There was a risk management policy in place which included all the requirements or the regulations. There was a risk assessment and management plan in place for most identified risks, including risk relating to

COVID-19.

A serious risk to a resident when travelling in a vehicle had been identified, but not mitigated. There were no control measures in place to ensure the prevention of a serious incident.

Judgment: Not compliant

Regulation 27: Protection against infection

Appropriate infection control practices were in place. Strategies had been implemented throughout the COVID-19 pandemic, and a clear contingency plan was in place. There were multiple hand hygiene facilities, and staff observed all infection control guidelines.

Judgment: Compliant

Regulation 28: Fire precautions

There was appropriate fire equipment including fire doors throughout the centre, and evidence that residents could be evacuated in a timely manner in the event of an emergency.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place for each resident, however they were not based on a detailed and contemporary assessment of needs. Where goals had been set for residents in relation to maximising their potential, these were sometimes not relevant to their needs, or were not based on any clear rationale.

Personal plans were either difficult to retrieve form multiple untidy folders, or were undated so that is was unclear whether they had been reviewed in a timely manner. Some sections of the personal plans were vague and lacked guidance for staff, some were generic and not person centred, and relevant information relating to learning from events which had occurred was not evident.

Judgment: Not compliant

Regulation 6: Health care

Required healthcare interventions were not always implemented. One of the care plans required fluid intake to be monitored and recorded for a resident who had a history of serious illness, but this had not been undertaken.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The management of behaviours of concern which had been implemented as a strategy to safeguard others included the frequent use of P.R.N medication. Less restrictive interventions or accommodations which would lessen the requirement for this medication had not been implemented.

Judgment: Not compliant

Regulation 8: Protection

Residents were not fully protected against any possibilities of abuse. The compatibility of of residents had not been addressed so as to ensure the safety of all. Plans to rearrange the accommodation so as to provide additional living areas had been approved by members of the multi- disciplinary team, but had not yet commenced, so that resident who posed a safeguarding issue to each other were living in close proximity.

Allegations against staff members were not addressed, investigated or mitigated in a timely manner.

Judgment: Not compliant

Regulation 9: Residents' rights

Whilst residents' rights were upheld to a large degree, and residents had choices in many aspects of their daily lives, residents were not all compatible with each other. Where one of the residents posed a risk to others, this had not been fully mitigated, and the steps taken to ensure the safety of others posed a significant infringement of the rights of the resident, who was been given medication to manage behaviours

of concern. This medication was reported as only being necessary to safeguard others on many occasions.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 19: Directory of residents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Avalon House OSV-0003694

Inspection ID: MON-0031727

Date of inspection: 07/10/2021 and 08/10/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Recruitment currently ongoing to fill vacant staff nurse posts. The PIC and PPIM ensure appropriate staffing rosters at all times to cover the safety, health and welfare of all residents. Staff levels are reviewed routinely to meet the assessed needs of residents and take account of the daily plan in place and required resident's supports. Staffing numbers are increased based on planned activities or scheduled appointments and staff work closely to ensure that the diary is used to plan the deployment of staff resources appropriately and staff rosters are managed to meet the personal, health and social care needs of residents.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A full audit of training was completed by PIC on 27/09/2021. A training matrix is maintained electronically to record all mandatory and professional development training. Required infection control certificates are now printed and on file for all staff. The PIC has updated the supervision timetable prioritising staff who are outstanding for 2021.Staff supervision meetings to support continuous professional development are being carried out and will be complete for all staff by 30/11/2021.	

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All records required by Schedule 3 of the regulations are being updated and a new index and divider system has commenced to ensure all documentation is readily accessible to inform care delivery and supports required by residents.
All information required by Schedule 3 of the regulations is available and on site and organized in individual folders pertaining to each resident to ensure care delivery in accordance with their assessed and planned care needs.
The organisational system to store folders has been reviewed to ensure ease of access to all required information.
All individual plans are being actively updated electronically from paper copies.
All goals and activities have been updated in line with resident's assessed needs and wishes.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC will continue with the regular schedule of audits in place consisting of weekly, monthly, quarterly, bi-annually and annually planned audits. An improvement action plan is implemented to ensure corrective action from any findings or recommendations arising from audits are completed.
A Schedule of audits is planned yearly in advance and is standard practice across the service in areas such as medication, finance, person centered goals, care plans, infection control, fire safety and Provider led 6 monthly and annual reviews.

A more detailed financial audit will now be completed twice per year. All audits as per the center's schedule are up to date.

The governance systems are further monitored through regular planned meetings with the ADON who is the nominated PPIM and who supports the Person in Charge in their role. The purpose of these meetings are to review all monitoring arrangements and ensure actions for improvement are being implemented and escalate any matters which may require the attention of the Provider Representative.

An unannounced six monthly visit was completed and an annual review of the quality and safety of care. Resident and relative questionnaires have been completed to elicit

feedback on the service and action plans implemented to address findings to ensure continuous quality improvement.

Notified incidents of safeguarding reported to HIQA are being investigated and the final outcome report from the review team commissioned is awaited. In the intervening period safeguarding measures have been implemented to protect all residents.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
However, due to limited computer access for staff due to the cyber-attack, all risk assessments were updated on a paper format. The computer was certified safe to use on 6/10/2021 and all risk assessments are now being completed electronically and printed off for each file.

All staff are knowledgeable and aware the car doors lock on acceleration and this control measure is updated and documented in greater detail on the resident's individualised risk assessment.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All individual plans are now being actively updated electronically from paper copies which had been updated manually on a paper based system as interim measure due to no access to computer for nursing staff due to IT system attack.
All goals and activities have been updated in line with residents assessed needs and wishes.
Three PCP meetings outstanding for 2021 have been carried out with action plans from these meetings agreed by all present.
Files will be updated with new index and wider dividers to ensure easy access of retrieval of documents.
All personal plans will be reviewed and updated to ensure they are sufficiently detailed and person centered to guide staff in their care interventions.

An incident log is completed at the end of each month that identifies areas for learning

and how they are achieved. The incident log will be a standing agenda item and discussed at each staff meeting to share information and communicate any lessons learned from incidents. Any learning identified from these reviews will be updated and recorded in resident's individual files.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
However, all healthcare plans have been updated electronically to specify identified current healthcare needs. Health care plans for residents have been reviewed to remove information which is no longer required.
Only information to guide staff interventions to respond to the current healthcare needs of each resident remains in the care files, which have been reorganised to ensure all data is readily accessible.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
However, PRN protocols in the aftermath of the inspection were reviewed and updated on 9/11/2021 in collaboration with nursing team, MHID, ADON and CNM2 to further ensure the validity of decision making for the prescribing and administration of PRN medication. The protocols guide nursing staff ensuring the least restrictive interventions and supports are provided as per the Positive Behaviour Support plan developed for the resident.

Positive Behavioural Support Plans in place were further reviewed and discussed with the Clinical Nurse Specialist in Behavior on 11/11/2021. A review of medication administration records and nursing notes show a marked decrease in the number of incidents over the last 12 months and a noticeable decrease in PRN being administered.

A further Mental Health ID review is planned for late November 2021 to discuss any further strategies and supports that can be provided to the resident and to review progress with current care interventions and positive behavioural supports that are in place to ensure they are meeting the needs of the resident in the least restrictive manner.

All behaviours of concern are recorded, monitored and reviewed by the multi-disciplinary

team. The intimate care plan for one resident which was updated on a paper format outlines the need for keeping nails short and for ongoing staff vigilance in regards to nail care which forms part of resident's daily personal care record in use.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Notified incidents of safeguarding reported to HIQA are being investigated and the final outcome report from the review team commissioned is awaited. In the intervening period safeguarding measures have been implemented to protect all residents. Where required Safeguarding Plans are developed and implemented to ensure the well-being and protection of each resident.

Individualised living arrangements for one resident are being progressed in line with their expressed wishes to be accommodated and continue living within the centre. The living areas are being reviewed to provide additional personal space and to ensure compatibility for all residents living in close proximity to ensure a safe, comfortable living environment that meets the living arrangements of all residents accommodated in the centre.

A business plan is currently being prepared for individualised accommodation to present to senior management.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: PRN protocols in the aftermath of the inspection were reviewed and updated on 9/11/2021 in collaboration with nursing team, MHID, ADON and CNM2 to ensure the validity of decision making for the prescribing and administration of PRN medication. This protocol will guide nursing staff ensuring the least restrictive interventions and supports are provided as per Positive Behaviour Support plan developed for the resident.

Individualised living arrangements for one resident are being progressed in line with their expressed wishes to be accommodated and continue living within the centre. The living areas are being reviewed to provide additional personal space and to ensure compatibility for all residents living in close proximity to ensure a safe, comfortable living environment that meets the living arrangements of all residents accommodated in the centre.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/12/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/11/2021
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30/11/2021
Regulation	The registered	Not Compliant	Orange	31/12/2021

23(1)(c)	provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/11/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/11/2021
Regulation 05(1)(b)	The person in charge shall ensure that a	Not Compliant	Orange	30/11/2021

	comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/11/2021
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	30/11/2021
Regulation 05(6)(c)	The person in charge shall ensure that the	Not Compliant	Orange	30/11/2021

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/11/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/11/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/11/2021
Regulation 08(2)	The registered	Substantially	Yellow	31/12/2021

	provider shall protect residents from all forms of abuse.	Compliant		
Regulation 08(4)	Where the person in charge is the subject of an incident, allegation or suspicion of abuse, the registered provider shall investigate the matter or nominate a third party who is suitable to investigate the matter.	Not Compliant	Orange	31/03/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/12/2021