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:	Tignish House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	07 & 08 November 2023
Centre ID:	OSV-0004262
Fieldwork ID:	MON-0041303

About the designated centre

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

Tignish House is a designated centre is located near a town in County Wicklow and is operated by Nua Healthcare. It provides a community residential service to four adults with an intellectual disability and autism. The designated centre is a detached two story building which consists of a kitchen come dining room, sitting room, a sensory room, a relaxation/TV room, a number of shared bathrooms, four individual bedrooms, a staff sleep over room and an office. The centre is staffed by a person in charge, social care workers and assistant support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Tuesday 7 November 2023	19:00hrs to 21:30hrs	Marie Byrne	Lead
Wednesday 8 November 2023	10:30hrs to 17:40hrs	Marie Byrne	Lead
Tuesday 7 November 2023	19:00hrs to 21:30hrs	Kieran McCullagh	Support
Wednesday 8 November 2023	10:30hrs to 17:40hrs	Kieran McCullagh	Support

What residents told us and what inspectors observed

This unannounced inspection was completed over the course of two days by two inspectors of social services. The inspection was completed to follow up on the actions outlined by the provider in the governance improvement plan they were implementing at the time of the last inspection in July 2023, and the actions outlined in the compliance plan following that inspection. The Chief inspector of Social Services had also received solicited information related to allegations of abuse, non-serious injuries for residents and restrictive practices in the centre which formed lines of enquiry for this inspection. The new person in charge and the director of operations facilitated this inspection.

There had been a high turnover of staff in the months preceding the last inspection. Since then the staff team had stabilised and a lot of work had been completed supporting staff to be aware of their roles and responsibilities in relation to the quality and safety of care and support for residents in the centre. While improvements were noted in relation to the premises and continuity of care and support for residents, there were a number of areas where further improvements were required such as, ensuring staffing was arranged around the needs of residents, the maintenance of rosters, the maintenance of records, infection prevention and control (IPC), risk management, and positive behaviour support.

Tignish house provides 24-hour care and support for up to four adults with an intellectual disability and autism. There were four men living in the centre at the time of the inspection. The centre is comprised of a two-story house in the countryside within a short drive of a large town in Co. Wicklow. There are four resident bedrooms, a large kitchen, a utility area, a living room, a main bathroom, two sensory rooms, a staff office, and a games room come staff sleepover room. There is also a large garage and a annex to the back of the property. There is a driveway to the front of the house, a polytunnel to the side of the house and a back garden with a sweeping view of the Wicklow mountains.

A number of times during the two days of the inspection, the inspectors of social services had the opportunity to meet and engage with the four residents living in the centre. On arrival on the first evening one resident and a staff member greeted the inspectors at the front door. The resident took a break from gaming to welcome the inspectors and to chat with staff. The other residents were either relaxing in their bedrooms or spending time in the shared areas of their home when inspectors arrived. They each appeared content and comfortable in their home and in the presence of staff supporting them.

Some residents told inspectors they were happy in their home, while others smiled and used gestures to indicate they were happy. Residents had lived together for many years and they appeared comfortable spending time together in communal areas during the inspection.The provider had completed a safeguarding/compatibility assessment which identified control measures to keep

each resident safe.

A number of works had been completed in the centre since the last inspection which had resulted it it appearing more homely and comfortable. Maintenance works were being completed on the second day of the inspection and more were reported and planned. Communal areas of the house and residents' bedrooms appeared clean; however, a number of areas including a number of bathrooms and some equipment were not found to be clean during the inspection and these will be discussed further under Regulation 27. Residents' bedrooms contained their personal belongings and they had their pictures and favourite items on display. Residents had mobile phones and Internet access. There were televisions, gaming systems and board games available in the house.

A number of staff spoke with the inspectors during the inspection about the activities that residents liked to take part in, and about their talents and skills. For example they described activities residents enjoyed regularly such as attending day services, shopping, swimming, going to the cinema, going for a walk, going to the gym, gardening in the pollytunnel, and listening to music. A number of staff spoke about how much one resident enjoyed taking part in the upkeep of their home by hoovering, doing laundry, and doing the dishes.

During the two days of the inspection, residents were observed spending time in their rooms, chatting to staff, listening to music, watching movies and going out-and-about with staff support. They had meals and snacks at a time that suited them. On the second day of the inspection one resident went out to engage in an activity they regularly enjoyed accompanied by a staff member. Two residents were supported by staff to go to day services, and the other resident was supported by staff to go visit their family member.

Throughout the inspection, kind, caring and respectful interactions were observed between residents and staff. Residents were observed to seek staff out should they require support and staff were observed to respond appropriately and to be familiar with residents' communication preferences

Residents and their representatives' input was captured as part of the provider's annual and six monthly reviews of care and support. In the latest six monthly and annual reviews residents and their representatives indicated that they were happy with care and support in the centre. There was information available and on display relating to areas such as complaints, safeguarding, and IPC. Keyworker and resident meetings were occurring regularly and during these meetings discussions were held in relation to advocacy, goals, rights, and meal and activity planning.

In summary, residents indicated they were happy living in the centre. Staff described meaningful opportunities for residents to engage in activities they enjoyed and inspectors observed residents taking part in activities they enjoyed at home and to leave the centre to engage in activities in the community. Residents were supported to stay in touch with the important people in their lives and to make choices and decisions about their day-to-day lives. A number of improvement had been made in the centre since the last inspection and more were planned. Areas

where further improvements were required were identified in areas such staffing, governance and management, IPC, records, risk management and positive behaviour support. These will be discussed later in the report.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

Overall, the findings of this inspection were that a number of improvements had been brought about as a result of the actions taken as part of the provider's governance improvement plan and the compliance plan from the last inspection. However, the effectiveness of some of the actions taken needed to reviewed by the provider as they had not fully addressed some of the areas where improvements were required. Overall, the provider needed to review their arrangements for oversight and monitoring in the centre in order to continue to self-identify and address areas where improvements were required. For example, in line with the findings of the last inspection some documentation required review to ensure it was fit-for-purpose, accurate, up-to-date, and guiding staff practice. IPC procedures and practices, and staffing arrangements to meet residents' needs also required review. Inspectors also found that risk management, positive behaviour support, and restrictive practices also required review by the provider.

The person in charge had the qualifications, skills and experience to fulfill the role. Prior to taking up a person in charge post they had worked in this centre for a number of years and residents were observed to be very familiar with them and very comfortable in their presence. They were motivated to ensure that each resident was happy, safe, in regular contact with the important people in their lives, and engaging in activities they enjoyed. The director of operations was also familiar with residents needs, visiting the centre regularly, and providing formal supervision for the person in charge.

The provider had a number of systems for oversight and monitoring in the centre but these were not found to be proving fully effective at the time of this inspection. The actions from their governance improvement and compliance plans had been implemented and had brought about the required improvement in some areas; however, some actions had not been fully effective as they were again identified as areas where improvements were required during this inspection. In addition a number of actions from the latest six monthly review in August were not fully effective as the inspectors found that improvements were still required in these areas. Examples included actions relating to documentation in resident' personal plans and risk management plans, and actions relating to IPC.

Overall, inspectors found that it was not demonstrated that staffing was arranged around the needs of residents. The provider had a centre specific staffing risk

assessment which identified that as per the assessed needs of residents five staff were required daily, including two sleepover staff. Staff who spoke with inspectors clearly identified the same staffing requirement and consistently spoke about the number of staff required to support residents to access the community as six. The staffing risk assessment identified that if staffing levels dropped below 5 that the centre's minimum safe staff levels were four, and three at times when two residents were at home.

Inspectors requested assurances during the inspection that minimum safe staff levels were in place for a number of dates as rosters indicated the centre was operating below minimum safe staff levels. The assurances that minimum safe staff levels were in place was provided on the second day of the inspection. However, assurances were not provided that optimum staff levels to meet residents assessed needs was not provided. For example, from the sample of rosters reviewed there were many occasions when the staffing number dropped to four and where the planned rosters indicated that relief staff were required; however, the majority of these shifts were not covered by relief staff. Inspectors acknowledge that on some of these days a member of the management team was available to provide direct support for residents; however, this was not always the case. There were planned and actual rosters in place and they were not found to be well maintained.

As the majority of the staff team were working in the centre less than a year they were in the process of settling into their new roles, and getting to know residents and the provider's policies and procedures. Significant work had been completed since the last inspection to ensure that were supported to access additional training, including bespoke area specific training. They were also in receipt of regular formal supervision to ensure they were performing their duties to the best of their abilities. In addition, competency checks were being completed using on-the-floor supervision and mentoring. A number of staff told inspectors that access to support and training, team-work, and shared learning had improved in the centre in the preceding months. Team meetings were occurring regularly and agenda items were resident focused. Incidents were reviewed and learning was shared at these meetings. The actions identified in the provider's governance improvement plan and the compliance plan following the last inspection were also shared with the staff team at team meetings. Staff who spoke with the inspector were found to be familiar with residents' needs and aware of who to go to if they had any concerns over any aspect of their care and support

Regulation 14: Persons in charge

There was a newly appointed person in charge in post. They were full-time and had the required qualifications, skills and experience. They were also identified as person in charge of another designated centre operated by the provider and were found to have systems in place to ensure effective governance, operational management and administration of this centre. They were very familiar with residents' assessed needs and motivated to ensure they were making choices in their day-to-day lives and

engaging in activities they found meaningful.

Judgment: Compliant

Regulation 15: Staffing

Overall, the number of staff required to meet the care and support needs differed across documentation reviewed during the inspection. Three out of four residents' assessment of need were not found to clearly identify the required staffing levels to meet their needs.

While inspectors were informed that there were enough staff on duty to meet residents assessed needs, it was not evident that staffing was arranged around the needs of residents. Inspectors acknowledge that the provider had completed a risk assessment which identified minimum safe staff levels.

There were planned and actual rosters; however, the actual rosters were not well maintained. For example, the rosters reviewed did not contain the second name of the relief staff who completed shifts, and over a four week period it appeared that minimum safe staff levels identified in the staffing risk assessments were not in place.

While inspectors got assurances that minimum safe staff levels were in place for the sample of rosters reviewed, assurances were not provided that optimum staff levels in line with residents assessed needs were in place. It was not clear why staffing levels were at four on many occasions as all residents were in the designated centre on those days. Inspectors acknowledge that on some of these days a member of the management team provided direct care and support for residents; however, this was not always the case. In addition, on the planned rosters for a one month period, there were 21 shifts identified where relief cover was required, but 19 of these went uncovered.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff team were in receipt of training to support residents in line with their assessed needs. In line with the provider's governance improvement plan the staff team had been supported to complete bespoke training in a number of areas to support them to be aware of their roles and responsibilities in the delivery of care and support for residents.

There was a supervision schedule in place to ensure that each staff had access to regular formal supervision. In addition, on-the-floor competency checks were being

completed with the staff team to ensure they were implementing policies, procedure and guidelines. Staff meetings were occurring regularly and the agenda was resident focused and key areas of service provision were being regularly discussed. There were opportunities to discuss accidents, incidents and near misses and to share any learning which came about as a result of reviews of these. Staff who spoke with inspectors said they felt well supported by the local management team.

Judgment: Compliant

Regulation 21: Records

In line with the findings of the previous inspection, inspectors found that there was conflicting information contained in a number of documents reviewed over the course of the inspection. Overall, some documentation required to ensure it was accurate and clearly guiding staff practice. For example, the information in some residents' assessments, personal plans and risk assessments contained inaccuracies or conflicting information. Examples of these were shared with the person in charge during the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure was clearly defined and staff had specific roles and responsibilities for areas of service provision. The provider had systems to monitor the quality and safety of care and support. However, some improvements were required to ensure that actions taken as a result of audits and reviews were bringing about the required improvements. For example, the provider had implemented a governance improvement plan and actions from the compliance plan following the last inspection. While these actions had resulted in a number of improvements, particularly relating to staff training and competencies and safeguarding, the actions had not been fully effective as inspectors again identified that improvements were required in relation to areas such as the maintenance of documentation, IPC, and staffing. Inspectors also identified additional areas where improvements were required in areas such as risk management, positive behaviour support and the use of restrictive practices.

Judgment: Substantially compliant

Quality and safety

Overall, from speaking with and observing residents over the course of the inspection, inspectors found that residents appeared happy and content in their home. They were being supported to keep in regular contact with their family and were being supported by their keyworkers to develop goals. They were taking part in activities they enjoyed both at home and in their local community. They were also supported to become aware of their rights and the complaints process. However, as previously mentioned improvements were required in relation to risk management, IPC and positive behavior support.

The provider had a risk management policy which contained the required information. There were arrangements to identify, record, investigate and learn from incidents. Learning following the review of incidents was shared across the team at handover and during staff meetings. There were arrangements to ensure risk control measures were relative to the risk identified; however these required review as the risk rating for some risks in the centre were not fully reflective of residents' needs or incidents occurring in the centre. This will be discussed further under Regulation 26.

The provider had policies and procedures to guide staff practice in relation to IPC; however inspectors found that residents were not fully protected by some of the IPC practices in the centre. There were cleaning schedules in place but they were not found to be fully effective as there were some areas and equipment that were not found to be clean during the inspection. Staff had completed a number of IPC-related trainings; however, inspectors found that there were gaps in staff knowledge in relation to cleaning procedures and managing soiled or potentially infectious linen.

Inspectors found that there was some guidance in residents' personal plans to support residents with behaviours that challenge or those who are at risk from their own behaviour; however, residents' plans required review to ensure they were clearly guiding staff practice. There were a number of restrictive practices which were being regularly reviewed to ensure they were the least restrictive; however, some restrictions required review to ensure they were the least restrictive, for the shortest duration, and risk assessed in line with the provider's policy. This will be discussed further under Regulation 7.

The provider was reporting and following up on allegations or suspicions of abuse or neglect in the centre in line with their own, and national policy. Safeguarding plans were developed as required, and were being regularly reviewed. Risk and compatibility assessments had been completed in the centre. The provider was found to be implementing a number of additional control measures to keep residents safe. For example, they were implementing a number of control measures to safeguard residents finances following a number of allegations of financial abuse in the centre. Staff had completed safeguarding training and those who spoke with inspectors were aware of their roles and responsibilities in relation to safeguarding and protection.

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests, and wishes. They had access to facilities for recreation and had opportunities to participate in community based activities in accordance with their wishes, capacities and developmental needs. For example, on the second day of inspection one resident was supported by a staff member to attend an activity of their choosing in the community, and two residents were supported to attend a choir group in their day service.

Residents were supported to develop and maintain personal relationships and links with their family and with the wider community. For example, on the day of inspection one resident was supported by a staff member to visit their family member and there was evidence that family contact was encouraged and facilitated if desired by residents. In addition, a number of residents were regularly staying overnight with their families.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk assessments pertaining to the centre and individual residents required review to ensure that they were reflective of the current risks in the centre to ensure that appropriate control measures were in place. For example, resident mobility was rated as a moderate risk on the register. However, no residents were assessed as at risk of falling within the centre.

Similarly, individual risk ratings did not reflect the current risks for residents. For example, one resident had recent incidents of engaging in self-injurious behaviour and this was rated as a low risk.

The use of personal protective equipment for protecting staff from possible injuries from any incidents involving residents was in place for some residents. However, following review of individual risk management plans, it was unclear why, as there was not a high risk or multiple incidents to demonstrate the need for this to be in place.

In addition, individual risk management plans referenced multi-element positive behaviour support plans, which were not in place for residents on the day of inspection. This required review by the provider.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had not taken adequate measures to protect residents from the risk of infection. Staff had completed a number of infection prevention and control related trainings; however, staff spoken with during the inspection were not familiar with protocols and procedures as set out in the provider's IPC policy and procedures. For example, staff spoken with were unsure of the correct procedure in relation to managing soiled or potentially infectious linen, or cleaning bodily fluids.

Inspectors were not assured on the day of inspection that there was effective and consistent cleaning being carried out in this house. For example, although there were daily cleaning schedules in place, and while staff spoken with indicated that cleaning was being done regularly, inspectors found a number of areas of the centre were not clean during the inspection. This included a number of bathrooms and some equipment in the centre. Inspectors also observed that cleaning schedules required up-dating to include the bath, showers and all en-suite bathrooms. In addition, there was no cleaning schedule in place for the garage, which stored a residents' Jacuzzi. On the first evening of the inspection, inspectors observed a large amount of water and residual mould on the surface which compromised the integrity of the product. This was not in line with best practice in relation to IPC and required review by the provider.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Staff spoken with informed inspectors that residents required support in promoting positive behaviour. Most staff directed inspectors to a section of residents' personal plans and two staff directed them towards positive behaviour support or multi-element positive behaviour support plans; however, following a review inspectors found that multi-element positive behaviour support plans were not in place for residents. Inspectors acknowledge that staff were knowledgeable in relation to residents support needs; however, the guidance in some residents' plans required review. For example, in one residents' plan it directed staff in relation to what to do if the resident displayed certain precursor behaviours which it stated were listed below; however, these precursor behaviours were not detailed below.

There were a number of restrictive practices in place in the designated centre. One restrictive practice was due for review at the next meeting as it was not evident that they had been implemented for the shortest duration possible or that the least restrictive practice was being used. It involved a keypad lock which was in place for one resident due to the risk of absconding. Staff reported to inspectors that the resident had not attempted to abscond in the past 12 months. Inspectors were informed that this restrictive practice was due for review with a view to implementing a restrictive practice reduction plan and this was documented in the

latest restrictive practice minutes. There was also a keypad lock in place on the staff office. It had not been recognised or assessed as a restrictive practice. There was no associated risk assessment in place as set out in the provider's policy on the Use of Restrictive Procedures.

Judgment: Substantially compliant

Regulation 8: Protection

Staff had completed bespoke training since the last inspection and staff who spoke with inspectors were very much aware of their roles and responsibilities should there be an allegation or suspicion of abuse. In addition, the provider had completed a safeguarding/compatibility risk assessment for each resident was supported to stay safe and were protected from abuse. These assessments identified vulnerabilities some residents may have and the control measures to implement to keep them safe.

Judgment: 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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tignish House OSV-0004262

Inspection ID: MON-0041303

Date of inspection: 07/11/2023 & 08/11/2023

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

1. The Person in Charge (PIC) in conjunction with members of the MDT team will complete a full review of Individuals Comprehensive Needs Assessments (CNA's) to ensure Individuals assessed needs are in line with their allocated funding hours. If any actions are identified out of this review these will be communicated to the Director of Operations (DOO).
Due Date: 10 January 2024

2. The PIC shall complete a review of 'actual' and 'planned' rosters in the Centre, to ensure staffing levels are correct and in line with Individuals assessed needs.
Due Date: 12 January 2024

3. The Centre's Staffing Contingency Plan will be reviewed and updated by the PIC to clearly outline the Staffing Arrangements in place to meet the assessed needs of Individuals as well as what measures are implemented to maintain continuity of care.
Due Date: 12 January 2024

4. The Statement of Purpose shall be reviewed and updated by the PIC as and where required to ensure staffing levels are aligned with the Centre's existing staffing levels and individual occupancy level.
Due Date: 12 January 2024

5. The above points will be discussed with the staff team.
Due Date: 22 December 2023

6. Following the completion of the above, the Quality Assurance Department will complete a full review of documentation completed for the HIQA action plan.
Due Date: 26 January 2024

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. The Person in Charge (PIC) in conjunction with the Behavioral Specialist will complete a full review of each Individual's Personal Plan's.
Due Date: 19 January 2024

2. The PIC will complete a full review of each Individual's Comprehensive Needs Assessments (CNA's) and Individual Risk Management Plan's.
Due Date: 10 January 2024

3. The above points will be discussed with the staff team.
Due Date: 22 December 2023

4. Following the completion of the above, the Quality Assurance Department will complete a full review of documentation completed for the HIQA action plan.
Due Date:26 January 2024

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Person in Charge (PIC) shall conduct a review of the Centres' cleaning SOPs to ensure that cleaning SOPs are specific to the designated Centre and there are cleaning systems in place for all areas in the Centre. Additionally, the PIC shall ensure the cleaning SOP's capture all specific sensory equipment which is required to be cleaned and a schedule will be implemented to ensure these are completed. Note: This was completed on 15 December 2023.

2. The PIC or in their absence a member of the Management Team will complete a daily hygiene brag and send these daily assurances to the Director of Operations (DOO).
Note: This was implemented on 15 December 2023.

3. The Person in Charge (PIC) in conjunction with members of the MDT Team will complete a full review of Individuals Comprehensive Needs Assessments (CNA's) to ensure Individuals Assessed Needs are in line with their allocated funding hours. If any actions are identified out of this review these will be communicated to the Director of Operations (DOO).
Due Date: 10 January 2024

4. The PIC shall complete a review of 'actual' and 'planned' rosters in the Centre, to ensure staffing levels are correct and in line with Individuals assessed needs.
Due Date: 12 January 2024

5. The PIC in conjunction with the Behavioral Specialist will complete a full review of each Individual's Personal Plan's.
Due Date: 12 January 2024

6. The PIC will complete a full review of each Individual's Comprehensive Needs Assessments (CNA's) and Individual Risk Management Plan's.
Due Date: 19 January 2024

7. The PIC will complete a review of the Centre Risk Register and Risk Summary document to ensure all controls are appropriately captured and documented.
Due Date: 11 January 2024
8. The PIC will complete a review of the most recent Provider 6 Monthly audit which was completed in August 2023 to ensure all identified actions have been completed.
Due Date: 29 December 2023

9. The PIC will complete the Centre's Annual Review Report which will provide a full review of the Centre for 2023.
Due Date: 29 December 2023

10. The above points will be discussed with the staff team.
Due Date: 22 December 2023

11. Following the completion of the above, the Quality Assurance Department will complete a full review of documentation completed for the HIQA action plan.
Due Date: 26 January 2024

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The Person in Charge (PIC) shall complete a full review of all Individual Risk Management Plans (IRMP's) to ensure all controls are appropriately captured and documented. Following this, the PIC will ensure they have appropriate systems in place for the ongoing monitoring and reviewing of IRMP's.
Due Date: 11 January 2024

2. The PIC will complete a review of the Centre Risk Register and Risk Summary document to ensure all controls are appropriately captured and documented.

Due Date: 11 January 2024

3. The above points will be discussed with the staff team.
Due Date: 22 December 2023

4. Following the completion of the above, the Quality Assurance Department will complete a full review of documentation completed for the HIQA action plan.
Due Date: 26 January 2024

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. The Person in Charge (PIC) shall conduct a review of the Centre cleaning SOPs to ensure that cleaning SOPs are specific to the designated Centre and there are cleaning systems in place for all areas in the Centre. Additionally, the PIC shall ensure the cleaning SOP's capture all specific sensory equipment which is required to be cleaned and a schedule will be implemented to ensure these are completed. Note: This was completed on 15 December 2023.

2. The PIC or in their absence a member of the Management Team will complete a daily hygiene brag and send these daily assurances to the Director of Operations (DOO). Note: This was implemented on 15 December 2023.

3. The Tignish House staff team will complete additional training in Infection Prevention Control (IPC) and providing Intimate Care for Individuals.
Due Date: 16 January 2024

4. Two (2) team members have been identified to be Subject Matter Experts (SME's) in IPC. These team members will receive training for this role and as part of this role they will support the Centre Management in ensuring high standards related to hygiene and IPC in the Centre.
Due Date: 10 January 2024

5. In addition to maintenance works already completed within the Centre, the Maintenance Manager will complete an onsite review with the PIC to ensure all maintenance works are captured. Following this, if additional maintenance works are required a schedule will be implemented to complete these in a timely manner.
Due Date: 21 December 2023

6. The above points will be discussed with the staff team.
Due Date: 22 December 2023

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

1. The Person in Charge (PIC) will review the guidance and behavioural definitions within each Individual's Personal Plans (Section 5) with the Behavioural Specialist.
Due date: 19 January 2024

2. The PIC in conjunction with the Behavioral Specialist shall complete a review of all Restrictive Practices within the Centre to ensure the least restrictive restraint is used for the shortest possible duration in line with national policy.
Due Date: 29 December 2023

3. The above points will be discussed with the staff team.
Due Date: 22 December 2023

4. Following the completion of the above, the Quality Assurance Department will complete a full review of documentation completed for the HIQA action plan.
Due Date: 26 January 2024

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.	Substantially Compliant	Yellow	10/01/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	12/01/2024
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are	Substantially Compliant	Yellow	26/01/2024

	maintained and are available for inspection by the chief inspector.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	26/01/2024
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.	Substantially Compliant	Yellow	11/01/2024
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated	Not Compliant	Orange	16/01/2024

	infections published by the Authority.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	19/01/2024
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	29/12/2023
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	23/12/2023