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:	Delta Oaks
Name of provider:	Delta Centre Company Limited by Guarantee
Address of centre:	Carlow
Type of inspection:	Short Notice Announced
Date of inspection:	22 September 2021
Centre ID:	OSV-0004712
Fieldwork ID:	MON-0034249

About the designated centre

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

Delta Oaks is a designated centre located close to the town of Carlow. The centre provides residential care for 11 adults, male and female, with intellectual disabilities aged 18 years and upwards. The centre comprises of three buildings; Tintean Dara, Tintean Eala and Tintean Rua. Residents have individual bedrooms in all three houses with shared kitchen and living areas. All three houses have access to open garden areas. Local amenities in Carlow include shops, café's, restaurants, a bowling alley, salons, GAA clubs and a cinema. Delta Centre day services and sensory gardens are also located close by. The staffing team consist of social care workers and support workers. Residents also have access to a staff nurse in the Delta centre if needed.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 22 September 2021	09:30hrs to 18:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

To gather a sense of what it was like to live in the centre, the inspector spent some time with residents, spoke with staff, and completed documentation review over the course of this inspection. Overall, the inspector found that residents' lived experience was being negatively impacted by insufficient staff numbers and limited access to behaviour support services.

There were some compatibility issues between a small number of residents living in this centre which had not been identified or addressed by the provider. The governance and management arrangements were not found to be effective at ensuring a quality-driven service was available to residents at all times. A number of issues were identified across a number of regulations on this inspection. This is discussed in further detail throughout this report.

The designated centre comprised three separate houses near a large town. One of the homes was located in a residential area, while the other two homes were located a short distance outside the town. All homes were large, well kept buildings, with more than adequate communal space for residents. They were individually decorated to residents' specific tastes and were homely and comfortable.

The inspector had the opportunity to meet with three residents. The inspector spent some time observing the routine and speaking with residents. During this observation, it was noted that the noise level of the environment was very loud. The assessed needs of the three residents differed, with some residents presenting as quiet while other residents required more staff attention and support. It was noted that one resident was very vocal at times and the other two residents sat in the room and listened to the loud level of vocalisations and expressed behaviours. Again, later in the day when residents returned, it was noted by the inspector again that the noise level became very loud due to the assessed needs of some residents.

During the observation period, staff interactions at this time were caring and supportive. Staff were observed to support residents in line with their assessed needs and provide redirection and support. However this was not effective in reducing the noise level of the environment.

With support, residents spoke about upcoming family visits. A resident proudly showed off their nails which had been recently manicured, and new shoes that they had bought. Choices were presented to residents as they discussed what they were going to do for the day. Residents' plans included attending the day service, going to a pre-arranged appointment, and then heading out for a coffee. Residents were provided with the choice of different coffee shops and restaurants. Residents' individual preferences were sought and respected. For example, a resident requested that they wanted to go for a soft drink instead of a coffee, this was immediately agreed too to by the staff member.

Documentation review from one of the houses, noted at times, that a resident expressed they were not happy with their living arrangements. The complaints log and resident meetings notes reviewed indicated that some residents stated they did not want to live in the house and that they were not happy with the support put in place. Although complaints were logged and were in the process of being reviewed, there appeared to be a delay in the provider taking action in relation to a complaint. For example, resident meeting notes dated 17 May 2021 indicated that a resident expressed their dissatisfaction in terms of the living arrangements. This was not logged as a complaint until September 2021.

The inspector reviewed a sample incident and accident reports and also Antecedent Behaviour Consequence (ABC) charts. These documented a number of incidents where residents had become distressed and subsequently engaged in behaviours of concern. The reports indicated the impact of the behaviour of concern on the other residents living in the home. These incidents had not been investigated in line with the organisations' policy and/or national policy in relation to safeguarding. The learning identified from these incidents was minimal and was not driving improvements in terms of the risk management and safeguarding procedures.The inspector requested that the provider complete a review of the accident incident log and ABC charts and retrospectively report all incidents in line with their policy and national guidelines. 13 safeguarding notifications were submitted following the inspection.

Taking into account the findings under the regulations during this inspection, the providers monitoring systems were not ensuring the service provided was always safe, appropriate to the needs of all residents, consistent, and effectively monitored.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 on the quality and safety of the service being delivered.

Capacity and capability

As stated previously, the inspector was not assured that the governance and management systems were always effective in driving quality and identifying areas of improvement. The centre was not adequately resourced in terms of access to some supports in line with residents' needs as well as the number of staff available to support residents. The inspection also reviewed the actions identified in the previous inspection report dated August 2019. Although some improvements had been completed, for example improvements were noted in Regulation 6, Healthcare. There was an overall level of deterioration with compliance with regulations that at times was negatively impacting on some residents' lived experience in the centre.

The inspector reviewed the provider's systems to monitor the quality and safety of care and support provided as required by regulation.The provider had conducted an

annual review as required under the regulations. There had been two six monthly unannounced quality and safety reviews dated October 2020 and April 2021. In addition, the Person in Charge had completed their own specific audit in July 2021. The areas reviewed included finance, fire safety, personal plans and medication. Some areas of concern were being identified and an associated action plan was in place. For example the provider had identified the ongoing need for access to behaviour support to ensure residents needs were being effectively met. However, despite the provider conducting unannounced inspections and an annual review of quality and care, the provider failed to self-identify some critical issues, such as safeguarding and risk, identified during this inspection. This highlighted that the arrangements in place were insufficient to drive the quality improvement required to enhance residents lived experience within the centre.

The resources available in the centre were not always adequate to meet the assessed needs of residents. A review of the staff rosters found that while there was continuity of care and support in the centre, there was at times insufficient numbers of staff available to support the residents effectively. At most times there was only one staff member in each home to support residents. This number of staff did not adequately ensure that appropriate supervision levels were provided at all times to minimise safeguarding risks and support residents effectively during incidents of behaviours of concern.

Regulation 15: Staffing

Although the staffing levels were in line with the statement of purpose, the inspector was not assured that staff levels were adequate to always support residents in line with their assessed needs. From meeting with residents, speaking with different staff members and from noting incidents that had occurred within the centre it appeared that staffing levels did not optimise sufficient support for residents at all times.

For example, on review of incidents and accidents, it was found that some residents became distressed on drives on the bus. All residents had to go together on these trips as there was only one staff member available to support the residents. Due to incidents of behaviour of concern some trips had to end and all residents had to return home to ensure the safety of all residents in the vehicle. During this time residents routines were interrupted.

On other occasions it was noted that residents were asked to leave the vicinity during an incident where a resident was engaging in behaviours of concern. As there was only one staff member present, there was limited support for all residents during this time.

Continuity of care was evident with a stable staff team in place to support the residents. There was a planned and actual roster in place.

Judgment: Not compliant

Regulation 16: Training and staff development

There were some gaps in staff being in receipt of training in mandatory areas and also in relation to training to support residents in relation to specific assessed needs. Although there were systems in place to identify these specific training needs, staff had not been put forward to complete this training to date. The following number of people had not completed training in the following areas.

· Managing Behaviour that Challenges: 4

· Autism Awareness: 3

· Hand Hygiene: 3

Judgment: Substantially compliant

Regulation 22: Insurance

The centre was insured against accidents or injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were not always effective to ensure the service provided was always safe, appropriate to residents' needs, consistent and effectively monitored. Although the provider's audits had identified some areas of quality improvement,they were not always effective in driving quality improvements. For example, the inspector identified a number of incidents on inspection that potentially met the criteria as safeguarding concerns. The management and oversight systems in place had failed to identify these incidents as such. Relevant actions were not initiated to maintain residents' safety at all times. Similar findings were found in relation to risk and complaints. These aspects of care had not been identified as areas of improvement in the provider audits.

Timely and consistent access to resources to ensure residents' assessed needs were being met were not always actioned. For example, there was limited access to positive behaviour support to ensure residents' specific needs were being supported effectively. On review of incidents and notifications, incidents describing behaviours

of concern, access to behaviour support services was required as a matter of priority.

Judgment: Not compliant

Regulation 34: Complaints procedure

While there were overall appropriate policies and procedures in place, some practices in relation to the management and documentation of complaints required improvements. There appeared to be a delay in responding to a resident's complaint. A resident had expressed dissatisfaction in relation to where they were living in May 2021. This was recorded as a complaint in September 2021. This complaint was investigated and an independent advocate was being sought to support the resident. The documentation required review to ensure all investigations and relevant time lines where appropriately reflected.

Judgment: Substantially compliant

Quality and safety

The inspector found that this centre's governance and management arrangements did not always ensure that the quality and safety of care delivered to residents was maintained to a consistently high standard. A number of non-compliance with regulations were identified in relation to residents' positive behaviour support, residents' rights, and safeguarding. Significant improvements were required to ensure a quality driven, safe service was provided to residents. Particular concerns were identified regarding the provider's ability to identify safeguarding concerns and how this sometimes affected residents' exercise of their rights in their home.

As stated previously, the inspector observed the noise level in the home was loud for a significant part of the day when all residents were present. This was due to differing assessed needs of the residents. Some residents were at times, impacted by the incidents of behaviour of concern. It was reported in the incident reports that other residents were 'upset' and 'distraught' on occasions.The systems in place had failed to identify incidents such as these as potential safeguarding concerns. Therefore the providers safeguarding policy and national guidelines were not followed in relation to these incidents. Safeguarding plans had been developed or updated following these incidents. From reviewing the documentation, the inspector was not assured that the supports in place were maximising the residents' safety at all times.

Compounding the issue of safeguarding was the providers ability to access support in terms of positive behaviour support plans and access to relevant professionals. This has been an ongoing concern since the previous inspection in August 2019. Although some minor improvements had been made as the service could now make a referral to access a behaviour support specialist, this was only available on a limited basis. On review of the residents' personal plans, it was found that some positive behaviour support plans had not been updated since 2015. A behaviour support plan dated June 2019 had been updated by a social care leader.

On review of the systems in place for responding to risk the inspector found that it was not always effective in identifying, recording and responding to accidents and incidents. Risk assessments and relevant control measures were in place for a number of identified risks. However, they were reviewed on an annual basis and not in response to relevant incidents that had recently occurred. For example, some fall risk assessments were reviewed in October 2020 and had not been reviewed in relation to recent minor falls that had occurred in the centre. The system in place to identify learning from accidents and incidents was not effective. The accident incident reports identified actions, however they described what immediately happened following an incident and not the overall learning piece that needed to occur. For example, following an incident describing a behaviour of concern the action was listed as 'staff gave the resident verbal attention'. There was no indication if this was effective or part of an ongoing strategy or control measure.

The Inspector reviewed residents' documentation and found that residents had a personal plan in place outlining the supports they required and also included an assessment of need. However, some of the information contained in the plans and assessments had not been updated. Other pieces of documentation dated back to 2014 and were possibly not relevant to the residents' specific needs at this time.

Regulation 17: Premises

The premises were designed and laid out to meet the number and needs of residents in the centre. The houses were found to be clean, comfortable, suitable decorated, and well maintained both internally and externally. Residents had access to private and communal spaces and could meet friends and family privately if they wished.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The inspector reviewed a recent transition plan that had been put in place for a resident. The resident had a long term plan to transition to a permanent residential

placement, they had been in receipt of respite services. The plan was resident focused and put their individual choices, needs and preferences to the forefront of the planning process. For, example the resident was involved in the decision making process around the location and type of premises.

Judgment: Compliant

Regulation 26: Risk management procedures

From the sample reviewed, It appeared that there was limited oversight of risk in the centre. The systems in place were not always effective in identifying, recording and learning from accidents and incidents. For example although risk assessments were reviewed on an annual basis they were not reviewed following significant incidents or patterns of incidents. For example, there was an incident recorded that described a resident leaving the centre in the absence of staff support. Although this incident was managed appropriately, it had not been identified as a potential ongoing risk, no risk assessment had been completed and no control measures had been put in place.

The systems in place for investigating and learning from incidents were not always effective. Actions identified following incidents only described the immediate action of staff. It did not always refer to ongoing control measures or specific strategies in place. From the review of a sample staff meeting notes there was no reference to some significant incidents or documented discussion around relevant risks.

Judgment: Not compliant

Regulation 27: Protection against infection

Residents were protected through the infection prevention and control policies, procedures and practices in the centre.The provider had developed contingency plans for use during the pandemic.

The premises was found to be clean throughout and there were cleaning schedules in place to ensure that each area of the centre were cleaned regularly.

There were suitable systems in place for laundry and waste management and there were also systems in place to ensure there were sufficient supplies of PPE available in the centre.

Observations indicated that staff were following the guidelines in relation to wearing masks appropriately and adhering to best practice in relation to different aspects of infection prevention and control recommendations.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, there were effective fire management systems in place. Suitable fire equipment was available and regularly serviced. There were adequate means of escape which were kept unobstructed, and emergency lighting was in place as required. Residents had personal emergency evacuation plans in place. Fire drills were occurring at regular intervals and took into account the least number of staff available to support residents during this process. There was documented evidence that a recent admission to respite had been involved in fire drills. Staff were knowledgeable in relation to the procedures and all staff had relevant fire safety training.

On the walk around of the premises, it was noted that a number of fire exits had door locking systems that required them to be opened with a key. There was some systems in place to ensure that the keys to these exits were readily available in the event of an emergency. However, these systems required review to ensure they were the most effective and safest means to ensure prompt evacuation of residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector found assessments of need and personal plans were not always up-to date to reflect residents' current needs and support requirements. For example, from a sample of documents reviewed, assessments and plans stated residents attended day services within the home. This had changed since the lifting of COVID-19 restrictions, however, plans had not been updated to reflect this.

Reviews of goals occurred, and it was evident that residents and their families had input to ensure they were meaningful to the resident. For example, one resident had chosen to learn how to use their mobile phone. There was corresponding documentation in relation to this, tracking the progress the resident was making with this specific skill. However, some goals identified by families and residents in the annual review had not been added to the residents' plan. Clarification around the selection of goals was required to ensure that residents' personal plans were updated accordingly.

Judgment: Substantially compliant

Regulation 6: Health care

In general, the inspector found that residents' healthcare needs were being met. Residents had access to nursing support when required. There was a range of allied professionals, such as clinical nurse specialists in epilepsy, chiropody, and dentists, to name a few. There was evidence that residents were facilitated to attend appointments in relation to the national screening program.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had identified the limited access to positive behaviour support as an area of improvement. This was also identified as a non-compliance in the previous inspection report dated August 2019. There was a long term plan to resolve this, and the provider was in the process of recruiting a relevant professional.

From a review of a sample of positive behaviour support plans, it was found that these were not updated on an annual basis, or as required, to ensure residents were effectively supported. For example one resident's positive behaviour support plan had not been updated since 2015. Plans that had been updated, were updated by social care leaders with limited input from relevant professionals.

Due to the limited input from a behaviour support specialist it was not apparent that residents plans were following the most up-to date evidence based practices. There was limited proactive management of behaviours of concern. There were no systems in place for tracking the effectiveness of plans in place. Incidents of behaviours of concern were occurring for a small number of residents, at times these incidents were impacting other people in the home. The information available on the day of inspection did not provide assurances that residents were being supported effectively in line with their relevant assessed needs.

Judgment: Not compliant

Regulation 8: Protection

The provider had not always ensured that residents were protected from abuse, and responsive actions had not always been taken by the provider to address some ongoing safeguarding and compatibility issues in the centre.

Incident review by the inspector appeared to indicate that a number of incidents potentially met the definition of a safeguarding concern and were not investigated

accordingly in line with the providers or national policy. Lack of adherence to national policy and best practice in relation to supporting vulnerable adults meant that safeguarding plans had not been updated or put in place following incidents.

The inspector requested that a review of the accident incident log was completed and all relevant incidents were reported, investigated and acted upon in line with the relevant policies. 13 notifications in relation to safeguarding were submitted retrospectively following inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

There were some positive practices in relation to residents' rights. Observations indicated that residents were given the opportunity to exercise some choice within their daily routines. Staff interactions were caring and kind and they treated each resident with dignity and respect.

However, the ongoing compatibility issues were at times impacting residents' routines. For example if an incident occurred on the transport vehicle, all residents would have to return home.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Delta Oaks OSV-0004712

Inspection ID: MON-0034249

Date of inspection: 22/09/2021

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
The provider will submit a funding request to the funders for additional staffing supports for the centres identified during the inspection. The DSAMT assessment completed resulted in the provider submitting a request for additional staffing of 136hrs per week. This request will be submitted by the 15th of November 2021, the staffing levels will be increased once the funds are agreed with the funder.

Day service will resume in the providers separate day service building 5 days per week, residents' day service will consist of differing activities and will be facilitated in different pods in the day service through individualized programs. This will commence on the 8th of November 2021.

Timeline: Funding Request will be submitted by 15th of November 2021.</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The organisation has committed to the services of a behavioural specialist for 2-year period who will commence a program of training staff in Universal positive behavioural Supports, this training will be completed in 2 groups, with both groups taking 8 months to train commencing in January 2022. This training will culminate in 75 staff having received comprehensive training in PBS. Staff that work with residents who require positive behavioural supports will be included in the first group of staff training.
Timeline: Group 1 training completed 30/9/2022</td></tr>
</table>

Timeline: Group 2 training completed 30/6/2023

ASD Training will be completed by all staff who work with individuals with ASD within 3 months of commencing their post. The staff identified from the Oaks inspection has now completed ASD training.
Timeline: Completed

Hand Hygiene training has now been added to the providers list of mandatory training. All staff have been notified of this and training matrix updated. Any outstanding hand hygiene training will be completed.
Timeline: 30/11/2021

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Audit systems have been adjusted as a response to the HIQA inspection of Delta Oaks. Specifically, the audit has been adjusted to identify that risk assessments have been reviewed and updated after incidents and that all complaints have been dealt with in a timely manner.
Timeline: Completed

A behavioural therapist has been employed by the organisation on a part-time basis and will commence this post from the 1st of November 2021, a priority list of residents who may require behavioural supports has been completed and these will be referred immediately to the behavioural therapist. This post will run in collaboration with the behavioural specialist who will complete the Universal Positive Behavioural supports training with staff.
Timeline: 1st of November 2021

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A review has been conducted of the complaints procedure and ensuring timely responses. Residents will continue to be supported to make complaints during their weekly house meetings or at any time an expression of dissatisfaction may arise. These complaints will be immediately forwarded to the PIC of the designated centre and

relevant actions completed. Staff in Delta Oaks have been informed of reviewed complaints procedure on 23/10/2021.

The complaints log will be reviewed by the PIC monthly to ensure that any complaint is actioned within an appropriate timeframe. Appropriate records of any investigations will be retained.

The complaints log will be reviewed quarterly at the review meeting with the residential manager.

The internal and external auditing systems have been updated to include complaints management is appropriate and in line with regulations.

Timeline: Completed

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk assessments will be reviewed on an ongoing basis, they will be discussed at all team meetings and any new risks identified will have assessments completed. Records will be maintained of these reviews.

Risk assessments will also be completed as a result of any incidents that occur in the designated centre and any existing risk assessments will be reviewed if an incident occurs pertaining to the risk assessment. These reviews will focus on learning and developing strategies to reduce the risk where possible.

Risk assessment reviews and incident management has been added to the PIC audits and to the external audits conducted on behalf of the provider.
TimeLine: Completed

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Break glass boxes with a spare key for the fire exit will be fitted at each fire exit throughout the premises. This is to ensure a swift exit from the premises if the existing key at each door is misplaced in the event of a fire.

Timeline: 15/11/2021	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Care plans and assessments of needs will be reviewed by keyworkers in Delta Oaks with the consultation of the residents they support. These plans will be updated to include the most recent information and will be updated on an ongoing basis by the keyworkers. Timeline: 30/11/2021	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A behavior therapist has been employed on a part time basis for the service, this post commences on the 1st of November 2021. The behavior therapist will be available to support residents and staff teams in managing behaviors of concern. A priority list of residents who may require behavioural support has been created and those on the list will be referred immediately. In addition to this and working collaboratively, the provider has committed to employing a behavior specialist for a 2-year period who will provide Universal positive behavioural supports training to staff members supporting residents presenting with behaviors of concern. This training will commence in January 2022 and over the course of 2 years will culminate in the training of 75 staff. Timeline: 1st of November 2021 Behavior therapist commences.	
Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: HSE Safeguarding team is scheduled to visit the organisation on 28.10.21 for a meeting with PIC's, Designated Officer, Residential Manager and CEO to provide training on safeguarding and clarify the definitions and threshold for safeguarding reporting. A small booklet of potential safeguarding scenarios will be discussed during the session to provide clarity to the team supporting residents going forward. Any incidents that may met the criteria of safeguarding will be reported in line with HIQA guidelines and HSE safeguarding team guidelines. The provider will be guided by both bodies in determining if the incidents meet the safeguarding criteria. Timeline: 28/10/2021	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Funding request will be sent to the funders by the 15th of November 2021, requesting additional staff supports for the residents in the designated centre. The provider will make a referral to the independent advocate on behalf of the residents of the designated centre. This referral will be made on the basis of establishing if peer compatibility is appropriate and to determine that the residents' rights within the designated centres rights are being upheld. Any complaint that a resident makes will be notified to the PIC immediately, these complaints will be dealt with in a timely manner. All actions/investigations pertaining to the complaint will be recorded and maintained. The complaints log will be reviewed quarterly at the review meeting with the residential manager. The internal and external auditing systems have been updated to include complaints management is appropriate and in line with regulations. Timeline: 15/12/2021	

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	15/11/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2023
Regulation	The registered	Substantially	Yellow	01/11/2021

23(1)(a)	provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Compliant		
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	03/11/2021
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	03/11/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	15/11/2021
Regulation	The registered	Substantially	Yellow	03/11/2021

34(2)(b)	provider shall ensure that all complaints are investigated promptly.	Compliant		
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	03/11/2021
Regulation 05(1)(b)	The person in charge shall ensure that a 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.	Substantially Compliant	Yellow	30/11/2021
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Substantially Compliant	Yellow	30/11/2021

	needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/06/2023
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	01/11/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/10/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action	Not Compliant	Orange	03/11/2021

	where a resident is harmed or suffers abuse.			
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.	Substantially Compliant	Yellow	15/12/2021