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:	Comeragh Residential Services Kilmeaden
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	10 July 2023
Centre ID:	OSV-0005094
Fieldwork ID:	MON-0040494

About the designated centre

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

In this centre, a full-time residential service is available to a maximum of five adults. In its stated objectives the provider strives to provide each resident with a safe home and with a service that promotes inclusion, independence and personal life satisfaction based on individual needs and requirements. This centre provides support for residents with high support needs. The number of days and number of hours each resident attends day service varies according to the individual needs and preferences of each of the five residents presently living in the designated centre. The house is staffed on a full time basis, which allows for flexibility around whether or not a resident goes to day service on any given day. Transport to and from this service is provided. Residents present with a range of needs in the context of their disability and the service aims to meet the requirements of residents with physical, mobility and sensory supports. The premises is a two storey residence. Each resident has their own bedroom and share communal, dining and bathroom facilities (two bedrooms are en-suite). The house is located on the outskirts of a village and a short commute from all services and amenities. The staff team is comprised of nurses and social care staff under the guidance of the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Monday 10 July 2023	09:00hrs to 17:45hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

Overall the inspector found a number of significant concerns on this unannounced inspection. These concerns primarily related to an absence of appropriate systems for the provision of rights based care and support to residents.

The inspector found that while an assessment of required staffing levels had taken place, staffing provision did not ensure residents were safe, had their care and support needs met and respected their rights at all times. These findings are reflected in high levels of non-compliance with the Regulations as outlined in the report and in the issue of an urgent action to the registered provider regarding staffing levels on the day of inspection.

This centre is a large two storey premises on its own site on the outskirts of a village in Co. Waterford. The centre is registered for a maximum of five residents and is home to five individuals. The inspector met with all five individuals on the day of inspection.

On arrival the inspector met with three residents who were getting ready for their day service. One individual was still asleep, staff reported that they have retired and were present in their home for the day. One other resident had already left for their day service. The inspector was told that not all residents attend their day service full time with some going for example on three days only. The house was busy in the morning with residents supported with personal care and provided with support to plan their day and ensure they had their belongings. Residents greeted the inspector and enquired about the purpose of the inspection and one resident asked whether the inspector would be reading files and stated they were happy for their plans to be read. The inspector thanked them. Residents explained that they had to take their lunch with them and they were supported to also take their daily plans and files which they took ownership of. Staff on duty were kind and prompted residents in a way that respected their independence where possible.

Not all individuals in the centre used fully verbal methods when communicating. The inspector observed residents using a variety of methods including vocalising, physical manipulation of their environment, directed eye gaze and use of photographs or visual aids. The inspector met with the resident who remained in the centre, over the course of the day. They were observed to be supported to start their day in a time line that met their needs.They were supported to engage in some table top activities such as puzzles. The staff ensured that drinks and food were available as requested and in a consistency as required in line with the resident's assessed needs. The inspector observed that the resident was supported in a kind and caring manner by staff throughout the day. The resident did not leave the centre on the day of inspection as the weather was very wet however, increased opportunities for the resident to engage in their community or with more meaningful activities in their home was found to have been discussed by the person in charge

and staff team with the resident now that they were retired.

Later in the day when the four residents returned one resident came to greet the inspector in the staff office. They spent time telling the inspector that they did not like being asked to leave their room or told what to do by a peer in the centre. The resident explained that they had asked to meet with the provider to discuss this and that this meeting had been scheduled. Changes in routine provide a challenge for a peer resident and as such when the resident who spoke to the inspector changed their routine in a way that had not been expected this had resulted in their peer directing the situation using a manner that had caused one resident distress.

Other residents on returning home went to their rooms to relax and one resident wanted to sit outside for a period of time. They enquired if the inspector had had a good day and stated it was nice to come home. The inspector introduced themselves to the resident who had not been present in the morning. They brought the inspector into the dining room to show them the photographs of staff who were working in the centre and to ask who would be present the following day.

The inspection was facilitated by the centre staff team and by a member of the provider's local management team. The staff present were familiar with the residents who were in the centre and spoke of how they were aware of providing levels of support to different residents according to their assessed needs. They were observed to be kind and caring to the residents in the centre and were familiar with systems that were available in the centre for them to follow when providing care and support. The inspector was shown detailed personal care support plans and the staff explained how they supported residents in many aspects of their health care.

In summary, while residents appeared well cared for during the inspection it was apparent that at other times there was not sufficient staff present to ensure that residents care needs were provided in line with the plans in place. Improvements were required in safeguarding, positive behaviour support and in the promotion of residents' rights in this centre. While the inspector acknowledges that some building work had been completed since the previous inspection ensuring the premises was more accessible to the residents who lived here, significant work was still required to ensure the centre was homely and well maintained. These areas identified as requiring improvement will be detailed later in the report.

The next sections of the report will outline the findings of the inspection in relation to governance and management, and how these arrangements impacted on the quality and safety of service being delivered to all who live in the centre. This will be done under two areas, Capacity and Capability and Quality and Safety.

Capacity and capability

The inspector found that this centre required improvement in the implementation of management systems and in completion of the provider's own identified actions in order to ensure it was well managed.

The provider had a management team in place that ensured levels of authority were evident, however, accountability for the actions and systems in place required improvement as they were not found to be effective in ensuring that residents well-being and independence were actively promoted. Improvements were required over Regulations as outlined below.

There were unannounced visits undertaken on behalf of the provider and actions were identified as a result, although the monitoring and times lines set for these required review to ensure they were effective. The inspector also found that robust auditing systems had not been consistently applied which supported on-going review of care. The providers' annual review was also available for review by the inspector. While there was a detailed quality improvement plan in place, the inspector found that a number of areas identified as needing improvement were still outstanding. The provider had identified actions for example, in financial safeguarding that had not been actioned/followed up in a timely manner and found other areas of fire safety that remained incomplete without any evidence that there had been any follow-up.

There was a core consistent staff team working in this centre however, there were a number of regular gaps on the centres rosters. The person in charge was also working on the roster a number of days a week to try and cover these planned gaps. Furthermore not all staff on the roster had completed training and refresher training in line with the providers policies, and residents' assessed needs.

Regulation 15: Staffing

Under this regulation the provider was required to address an urgent risk that was identified on the day on the inspection. The provider was requested to provide a written assurance, following a review of their staffing arrangements, to the Chief Inspector of Social Services, following this inspection.

The inspector found that the staffing resources in the designated centre were not provided in line with the assessed needs of the residents at all times. This was found to negatively impact the rights of residents in the centre and the potential safety of residents in emergency situations. In addition, staffing levels provided at times were not in line with control measures, stated as required in risk assessments, did not allow for the implementation of strategies laid out in positive behaviour support plans nor to meet the requirements for following safeguarding plans.

The inspector reviewed the current roster and observed on the day of inspection three members of staff on duty with, for the most part, one resident in the centre. However, later in the day from 20:00 a single staff member was on the roster to support five residents until 08:00 the next morning. This allocation at night was not

in line with the assessed needs of residents as stated by the provider and person in charge.

There were gaps on the roster for this centre that were as a result of planned staff leave for the most part, and while the person in charge provided some cover, agency staff were regularly used and identified on the roster. This resulted in an inconsistency of staffing support for residents in the centre.

There appeared to be no plans to address staffing needs to ensure the residents' specific support needs were being adequately and safely met despite this having been identified as a concern in the previous inspection of this centre. Previously identified concerns that a lone staff member could not implement the plans devised to ensure the safety of all residents remained the case at this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training and development systems in this centre were found to be inadequate.

A number of staff were required to complete training in mandatory areas including fire safety, medication administration and manual and patient handling. Manual and patient handling for example had a direct impact on the safety of residents requiring hoisting to safely move from one location to another. In addition, the absence of this manual and patient handling training directly impacted on the potential arrangements for safe evacuation of residents in the event of a fire.

Staff had also not completed training that would support them in working with behaviours that challenge, this was of importance as staff had no training in the specific strategies identified as required in positive behaviour support plans.

Given the complexity of healthcare needs in this centre, in addition to the presentation of behaviours that challenge and changing needs of residents, it was not apparent that all core and agency staff providing care and support had the range of resident specific skills required. This was of particular importance if in a position of lone working, but was also of importance for all staff in engaging with residents. Where a resident had identified communication needs and following assessment a requirement to support their communication through the use of a manual signing system called Lámh. The inspector found that the majority of staff had not been in receipt of Lámh training and nor was its use observed in practice over the course of the day.

Judgment: Not compliant

Regulation 23: Governance and management

While the provider had identified lines of authority in place in this centre they were not effectively identifying and managing the service in a manner that promoted the residents rights and ensured they received a safe level of care and support. There was documented evidence that the members of the centre management team were present in the centre however, areas within the centre identified by the inspector as requiring improvement had not been reviewed by the centre management. This did not provide assurance that all areas within the centre were adequately monitored.

The provider was completing reviews in line with the requirements of the Regulation such as an Annual review and six monthly unannounced audits however, the inspector found that not all actions identified on these were being followed up or reviewed. For example the location of furniture had been identified as preventing fire doors from closing six months prior to the inspection and furniture was in the same location on the day of inspection. The providers audits were not only identifying actions that were required they also identify the lack of timely responses to actions. These responses to actions remained a concern but there was no identified action to improve these and the position remained unchanged which did not assure the inspector that a safe service was being delivered at all times.

A sample of audits at centre level were occurring that did not identify areas of improvement or identify gaps in the provision of safe and quality care. Staff when asked to explain to the inspector the detail in some audits were unclear what they were reviewing or checking and these were discussed with the management team on the day. Other audits for example those completed quarterly were found to have identical actions brought forward,despite them having been marked as completed three months prior. This did not demonstrate learning from information that was being gathered.

The outcome of not having appropriate management systems consistently in place is reflected in the range of findings of non-compliance in Regulations as detailed in this report. Of particular concern the lack of oversight did not ensure that residents' rights were respected and upheld at all times nor that residents were safeguarding in all areas. This is outlined further under Regulations 8 and 9 below.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all notifications had been submitted in line with the time frames as set in the Regulation. In addition, not all incidents that required notification had been

identified as such. This included potential safeguarding incidents that were managed as complaints and not managed via the provider's own internal notification system.

The inspector found that not all quarterly notifications had been submitted within the time frame required and also that a number of incidents that should have been submitted at three days had been submitted late, one at 16 days post incident.

Judgment: Not compliant

Quality and safety

The inspector was not assured that all residents were appropriately safeguarded at all times. Overall, the findings of this inspection were that improvement was required to ensure that residents were protected and their rights upheld in this centre.

As part of the management of some peer to peer compatibility challenges for example, a decision was recorded for one resident regarding where they had their meals. This highlighted that for one resident, due to incompatibility concerns, the person in charge had offered them the option to eat on their own and not in the dining room with their peers.

This was presented as a choice to the resident but this was not replicated for other residents. As a result one individual ate the majority of their meals not with their peers but on their own in their bedroom. This decision as outlined to the inspector appeared to have arisen from an anxiety not to spend their time with peers due to the resulting behaviours of concern. This resident was observed as increasingly isolated within their home and their ability to move freely in their home had been significantly curtailed. The inspector found that the providers responses regarding the assessed levels of staff support to mitigate against situations such as these were not being applied consistently.

It was apparent to the inspector that the staff team in place were endeavouring to maintain and support residents' quality of life and overall safety of care although some documentary improvements were required.

Regulation 17: Premises

This centre comprises a large two storey house set in its own grounds on the outskirts of a large village in Co. Waterford. Internally there is a large communal living room, a smaller dining-living room and kitchen. There is a staff office and staff

bathroom also on the ground floor. All residents have their own bedrooms two of which are en-suite. Two residents have shared access to a bathroom downstairs and one resident has sole access to a bathroom upstairs along with their own small living area as part of their bedroom. The provider had laundry facilities available in a shed located close to the rear of the house. This area of the property was not indicated as part of the designated centre. The inspector did observe that this was not accessible to all residents as there was a step up into the shed and limited space for wheelchair users internally.

Internally the house requires substantial maintenance, to the kitchen in particular where the tiled flooring was cracked and press doors were worn and in disrepair. This area had been identified by the provider as part of a property review. In the living room where laminate flooring was cracked or worn, black masking tape had been applied to cover the damage. Velux windows reported to be in poor condition on the previous inspection remained waiting to be replaced and were seen to be visibly unclean.

Upstairs there was a room allocated for storage and the inspector viewed this along with a member of the centre management team. It was apparent that this room had not been reviewed by the provider or person in charge in some time. It was in significant disarray with residents' belongings such as suits or winter clothing in piles, falling out of wardrobes or in black bags. This did not demonstrate respect of residents personal possessions.

Externally the inspector found that the provider had completed works identified previously that improved accessibility for residents to some of the paths and hard surface areas. Residents continue to be unable to access the rear garden which is large and private as it was set to grass and not wheelchair accessible. However the staff team had endeavoured to make the front of the premises inviting for residents with flowers planted and a gazebo and seating area. There are risks inherent in using this area as it is the driveway and also used as the centre car park with vehicles entering the premises having to drive around the gazebo prior to parking.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had a risk management policy and process in place. The inspector acknowledges that the risks within the centre were identified and assessed however, control measures in place were not being adhered to for risks that the provider and person in charge had assessed as moderate to high in their assessments. This demonstrated limited evidence of appropriate risk management the impact of which meant safe care was compromised for residents.

Where the risk for residents living together due to compatibility concerns was assessed as being of a moderate to high concern the control measure was that staff

were assigned to support one individual whenever they were in the house. This could not be met when there was lone staff on duty from 20:00 for example. Where there were other identified potential safeguarding risks where residents moved through the house at night the risk assessment stated as a secondary control in August 2022 that a second staff member should be appointed at night and this had not been implemented.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had a policy and procedures in place to protect residents from the risk of healthcare associated infection. The condition of the premises as already identified under Regulation 17 did not allow for effective cleaning in all areas despite the staff teams observed efforts. In addition, the cleaning schedules in place did not include all areas within the designated centre such as the storage room upstairs which was not only in disarray but visibly unclean. The inspector found gaps in the recording against tasks on the cleaning schedules. The inspector acknowledges that the staff team did clean the centre throughout the day of inspection.

The inspector found that the risk of potential water borne disease was also not mitigated against in the centre with two sinks upstairs not identified as requiring water to be run through them. The staff and management team could not provide a response as to the last time the sinks had been used and the water flushed through. While the provider had introduced colour coded cleaning equipment which was in use, the mops were hung outside against an external uncovered wall and the mop heads remained attached to the mops throughout the day of inspection and not protected from the weather.

Where individuals due to their healthcare needs used for example catheters, the cleaning of these and the associated equipment was only identified for one resident and not others. There were a number of sharps bins in the centre for the management of needles and for monitoring of diabetes and the inspector found that not all were dated on opening.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had systems in place for the management of fire safety in the centre however, improvement was required in a number of areas including evacuation practices, containment of fire, auditing and identification of issues relating to fire safety. Staff were completing fire safety audits that were called 'fire register' and

when asked all staff responded with different areas they thought were included on this checklist. It was not clear for example if regular checks of all fire fighting equipment were being completed.

The inspector found that three fire doors did not fully close on the day of inspection none of which had been identified in centre audits, this included a storage room upstairs that was full of combustible material and two residents bedrooms. One residents' bedroom door was noted to have an over-the-door hook in place that had damaged the integrity of the fire seal in addition the door to the store room used for personal care items was catching on a shelving unit when opening and closing which had also damaged the integrity of the fire seals. As already stated in the report the dining-living room door which was between there and the kitchen was prevented from closing due to the location of a sofa. Which while identified by the provider had not been addressed in a six month period. The inspector and staff moved the sofa on the day and found that the door did not fully close and this required review. The inspector acknowledges that for a resident the movement of furniture from a preferred location will take time but no plan to address this had been in place since the action was identified.

The inspector observed that the shed for the laundry facilities which was not part of the designated centre but located in close proximity to the back door had no smoke alarms or any fire fighting equipment. Fire drills were recorded as happening in line with the provider's policy however it was not evident when a drill with all residents and minimum staffing had last occurred. For one individual evacuation using their bed was noted as a possible means of leaving the centre but there was no evidence that this had been trialled during a drill.

Where the fire alarm had activated which was not a planned drill in October 2022 lone staff had documented that they would have been unable to evacuate all residents, no evacuation took place on this date despite the alarm activating. It was not apparent what follow up actions had been taken in response to this and no drill had been recorded as trialled following this incident. The inspector acknowledges that the provider had requested a health and social care professional to assess the ability for a lone staff member to transfer residents who require hoisting without a second staff member prior to this incident in June 2022. The assessment states that 'a trained person would be capable in the case of an emergency' however as stated under Regulation 16 not all staff were trained in the area of manual and patient handling. In addition from review of drill records including the incident from October 2022 this advice has also not been trialled.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The previous report from this centre stated that there were 'concerns in relation to the behaviours of a resident that impacted on all other four residents', this remains

the case at the time of this inspection although the inspector acknowledges that the volume of adverse incidents has reduced. The inspector also acknowledges that for one resident there has been substantial intervention by health and social care professionals in particular psychology. While this level of support is positive and has had a positive impact for one individual there remains an impact on other residents arising from the behaviour that challenges. The need for areas of the home and routines to remain consistent for one individual has resulted on restrictions and limits placed on others as self-reported by one resident who when not hungry and wanting to relax and watch television was directed to leave their room and join the mealtime even through they did not want to. This was outlined to the inspector by a resident who was not happy about this.

Where required, residents had comprehensive positive behaviour support plans in place. The inspector reviewed these and found them to be up-to-date and monitored by relevant professionals. However, where they require specific training or skills to be in place for staff to implement these plans these had not been consistently provided. Equally as a result of effective staffing arrangements at night time not being in place to ensure staff could exercise professional responsibility the services they were delivering, these behaviour plans could not be implemented.

Judgment: Not compliant

Regulation 8: Protection

While the provider had a safeguarding policy and procedures in place the cumulative findings of this inspection did not assure the inspector that residents in this centre were safe at all times.

Improvement was required in the management of residents' finances. The provider had completed a number of audits specific to safeguarding of residents finances. These audits had identified a number of safeguarding concerns whereby arrangements were in place that had resulted in residents not receiving all of their allocated social welfare payments. The inspector found that no plans had been devised or put in place to address these self identified concerns. Residents' monies were not for instance being paid to them rather being paid to others either wholly or in part who supported them outside of the organisation. Further there was no oversight of some residents' transactions, bank statements or savings and the provider had no system of ensuring residents finances were safe. Overall financial practices required review, the inspector found that on the day of inspection one residents wallet had been reported as missing two days prior to the inspection. It was recorded in a staff communication diary and while it was later found in another residents bag no report had been made using the provider's safeguarding pathways.

Safeguarding plans in relation to peer to peer incompatibility were developed as required however, the inspector found that for one newly implemented interim plan it was unclear whether it had been reviewed as required as no review dates were

documented. In addition as previously stated, the impact of not having effective staffing at all times did not support the implementation of safeguarding measures as identified in the plans. The absence of systems in place to ensure a resident's safety when they were left unsupervised did not assure the inspector that the safety of care was prioritised for all individuals in this centre.

Judgment: Not compliant

Regulation 9: Residents' rights

This inspection identified very poor practices in relation to residents' rights. The inspection findings indicated that residents' choice and control within their home was limited at times. As already stated one outcome of ineffective staffing arrangements resulted in two residents who did did not consistently get to make decisions and choices regarding the time they went to bed. This decision was made based on the staffing levels in the centre.

Another resident while reportedly given a choice on eating on their own or with others where there are reported concerns due to the presence of behaviours that challenge selects to eat on their own and to remain in their room as they feel at risk moving through their home. For the other residents in the centre the choice to engage in their community or participate in an individualised activity in the evening is not possible again due to the implementation of staffing arrangements.

Further consideration was required in relation to the provision of facilities and practices that maximised residents' independence this relates to the physical layout of their home, for example an inability to access the laundry area due to the presence of a step or to use the rear garden due to the condition of the surface.

Where some residents were supported by others outside of the provider regarding the management of finances any decisions to purchase items or plan activities relied on permission from others thus reducing the amount of freedom to make a choice or decision. The respect for residents' possessions was also found to require improvement as already stated a storage room was used to store some of the residents belongings where there was not space in their bedrooms. This included for example, winter clothes in the summer or suits and other infrequently worn items. These possessions were not found to be stored in a manner or condition that demonstrated respect and they were not accessible for residents to access without support, it was unclear how it had been determined what would be removed from a residents room and put into storage and whether the residents were part of this process.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Comeragh Residential Services Kilmeaden OSV-0005094

Inspection ID: MON-0040494

Date of inspection: 10/07/2023

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A roster review has been completed in line with residents assessed needs. The revised roster allocates 2 staff to be on duty in the evenings from 20.00 to 23.00 effective from 19/07/2023. • This revised roster will ensure sufficient staffing to effectively implement behavior support strategies and safeguarding plans. The increased staffing will also enhance residents rights and opportunities in the evening up to 23.00 • In conjunction with the revised staffing arrangements an analysis of all training for staff has been undertaken and required training for staff is being prioritised. • A night time fire drill has been carried out since the time of this inspection with maximum occupancy (5) and minimum staffing (1). The full evacuation time for the drill was 3:05 and demonstrated that all residents could be evacuated safety and promptly within an appropriate timeframe.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC has reviewed the training records of the staff team and in conjunction with the training department the following training has been organised as a priority:	

• 8 staff are scheduled to attend training for Safety intervention level 1

• 4 staff are scheduled to attend fire training

• 5 staff are scheduled to attend manual handling patient transfer training

• 4 staff are scheduled to attend safe administration training refresher

• 4 staff are scheduled to attend Lamh training

• 3 staff are scheduled to attend diabetes training.

• 5 staff are scheduled to attend Catheter care training.

• The PIC will ensure that any agency staff nurses being used in the centre have the required competency in management of diabetes, epilepsy, catheter care and safety intervention level 1.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Actions identified in audits and HIQA Inspections which form part of the centres overall quality improvement tracker will be subject to monthly reviews by the PIC and services manager.

• All required fire safety checks including the confirmation that fire doors are not obstructed will be carried out in line with the fire register.

• There will be increased oversight of the required fire safety checks by the PIC and this will be subject to regular monitoring by the Service Manager during in person visits to the centre.

• A robust system of auditing will be implemented to identify and address issues in the designated center. The service manager will have oversight of audits and corresponding actions as they occur.

• The Service Manager will visit the centre on a fortnightly basis and attend staff meetings which are being increased to occur on a monthly basis

• The service provider will review the arrangement for the financial management of two residents whose monies are not managed by the services and implement a plan for the management of finances in line with their rights. This will be completed in conjunction

with resident's families.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC will ensure that notifications are submitted within regulatory timeframes on a consistent basis.

• All concerns/allegations of abuse will be notified by the PIC to HIQA within the required timeframe.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Provider will undertake a review of the physical layout of the premises with a view to making internal and external areas more accessible for residents. This review will also take into consideration the reconfiguration of the patio area to the rear of the house to mitigate concerns regarding the parking of cars at the front of the house.

• The PIC is in the process of obtaining quotes for kitchen replacement and to include replacing floor and wall tiles.

• Costing is being sought to replace flooring in the living room.

• Refurbishment work will be carried out on both Velux windows, this is being overseen by the facilities manager.

• Items being stored inappropriately in a spare upstairs bedroom have been removed and the room has been reorganised to ensure that it can be cleaned effectively and is not cluttered.

• The staff team will engage with the residents on management of their wardrobe and all personal clothing will be stored appropriately in resident's own bedrooms.

• A new storage shed is ordered to store non-personal, household items.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A roster review has been completed in line with residents assessed needs. The revised roster allocates 2 staff to be on duty in the evenings from 20.00 to 23.00 effective from 19/07/2023.

A full review of the risks within the centre will be carried out to ensure that control measures in place are robust and implemented

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The PIC is in the process of getting quotes for kitchen replacement and to include replacing floor and wall tiles.

• The cleaning schedule has been updated to include all areas of the centre and all equipment in use.

• There will be monitoring on a daily basis by the shift leader of the cleaning schedule to ensure all scheduled cleaning is completed. This will also be subject to increased oversight by the PIC and Service Manager.

• Both sinks upstairs in unoccupied bedrooms have been removed.

• A protection canopy has been installed where mops are stored to protect them from the weather.

• The sharps box will be managed in line with organizational policy and best practice. This will be subject to monitoring/checks as part of the weekly medication audit.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Since the time of this inspection, a nighttime fire drill was undertaken with maximum occupancy and minimum staffing which demonstrated all residents could be evacuated in a safe, timely manner. • 5 staff are scheduled to attend manual handling patient transfer training • A daily check will be completed by the shift leader to ensure all fire doors are free from obstruction. This will be recorded as part of daily check list. • Issues related to the 3 fire doors not closing on the day of the inspection have been rectified. • A weekly check of fire door closures will be conducted and issues notified to relevant contractors to ensure that issues are rectified in a timely manner. • Work to support one resident's need to move furniture will be addressed by psychology in their BSP in consultation and with the support of the speech and language therapist. • A fire call point has been installed in laundry room which is connected to the fire monitoring system. A fire extinguisher has been provided in the laundry area also.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • 8 staff are scheduled to attend training for Safety intervention level 1 (Previously known as MAPA) • The Psychology team in conjunction with the multi-disciplinary team will continue to provide ongoing support to the staff team to guide practice and mitigate the occurrence of any negative interaction that may arise between residents. • Work to support one resident to manage the challenges of their environment will be addressed by psychology in their behavior support plan in consultation and with the support of the speech and language therapist. • 4 staff are scheduled to attend Lamh training. • A compatibility assessment will be undertaken by the multi-disciplinary team, which will inform future service planning.	

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The service provider will review the arrangement for the financial management of 2 resident whose monies are not managed by the services and implement a plan for the management of finances in line with their rights. This will be completed in conjunction with resident's families.

• Oversight of all finances of people supported in the residence will be provided in line with the organisation's policy.

• All discrepancies in finances of people supported will be addressed in line with organisational policy with oversight of the PIC.

• Safeguarding plans in relation to peer on peer incompatibility will have identified review dates and these will reviews will be carried out in line with the organisations policy on safeguarding.
• A new staffing roster is implemented to provide appropriate supervision in line with safeguarding plans

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A roster review has been completed in line with residents assessed needs. The revised roster allocates 2 staff to be on duty in the evenings from 20.00 to 23.00 effective from 19/07/2023

• The increased staffing will also enhance residents rights and opportunities in the evening up to 23.00

• Daily check in with residents to ascertain choices about where they wish to have their meal is recorded and facilitated.

• Work to support one resident to manage the challenges of their environment will be addressed by psychology in their BSP in consultation and with the support of the speech and language therapist.

• The service provider will review the arrangement for the financial management of 2 resident whose monies are not managed by the services and implement a plan for the management of finances in line with their rights. This will be completed in conjunction

with resident's families

• The staff team will engage with the residents on management of their wardrobe and all personal clothing will be stored appropriately in resident's own bedrooms.

• The Provider will undertake a review of the physical layout of the premises with a view to making internal and external areas accessible for residents.

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	Red	19/07/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	01/08/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Not Compliant	Orange	31/12/2023

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/10/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/10/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	01/08/2023
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	31/10/2023

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.	Not Compliant	Orange	31/12/2023
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	01/08/2023
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	Not Compliant	Orange	01/08/2023

	associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/08/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	31/07/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/09/2023
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation,	Not Compliant	Orange	31/07/2023

	suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2023
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.	Not Compliant	Orange	31/10/2023
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	31/10/2023

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	01/08/2023
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	31/10/2023
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	01/08/2023