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:	Country Lodge
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	14 January 2021
Centre ID:	OSV-0005827
Fieldwork ID:	MON-0031320

About the designated centre

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

Country Lodge is a residential home located in the county of Kilkenny. It provides a full time residential service to four individuals over the age of eighteen whom present with an intellectual disability. This is a high support home, with a requirement for three staff during the day and two staff on night duty. The mission of the centre is "to enable people to live a good life, in their own home with supports and opportunities to become active, valued and inclusive members of their local communities". Individual support needs are reflected within personal plans which are reflective of the holistic needs of the person including their medical and social needs. Nursing care is provided within Country Lodge to monitor and ensure the individual's health care needs are being met and health care staff is part of this process and involved in any changes to the individual's health care plan.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Thursday 14 January 2021	10:30hrs to 16:30hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

This inspection took place in the backdrop of the COVID-19 pandemic. Communication between the inspector, the residents, staff and management took place in adherence with public health guidance. To comply with the Health Information and Quality Authorities (HIQA) enhanced inspection COVID-19 methodology the inspector kept footfall throughout the centre to the minimum required in order to complete the inspection.

From what the inspector observed, residents in this centre were content and well cared for and were overall afforded a good quality of service. This inspection found that some improvements were required in relation to the remit of the person in charge to ensure that full oversight could be maintained, including ensuring that formal supervision of staff was occurring within the time-lines reflected in the organisations policy and that documentation relating to risk was being reviewed regularly. Some improvements were also required in relation to person centred planning for residents and ensuring that residents were offered sufficient activation on an ongoing basis.

There were four residents living in this centre at the time of this inspection and the inspector met with all residents. The residents in this centre did not communicate verbally. Residents were observed and overheard going about their day and were seen to be content in the company of staff and management of the centre. All residents in this centre availed of significant supports and all were wheelchair users with varying levels of mobility. One resident was in the front yard on the inspectors arrival and was seen to independently navigate in and out of the front door to spend time outside as desired. Residents were seen to be suitably dressed for the weather conditions when going outside. Residents were observed interacting with one another and staff, at mealtimes, and attending to activities of daily living as required. There was a movable height table in place in the kitchen and the person in charge told the inspector that this was a recent addition and was utilised regularly by residents for table-top activities and meals. One resident was observed carrying a ball and staff told the inspector that this was a preferred item and activity for this individual. Residents in this centre used a variety of communication means to interact with staff and communicate their preferences. Staff were seen and heard to interact positively with residents throughout the day and residents were seen to spend time in communal areas as well as enjoy time in their own bedrooms.

The centre, a detached bungalow, was homely, well lit and ventilated, and contained required aids and appliances to assist residents with mobility and personal care needs such as overhead hoists and accessible bathing and shower facilities. It was seen to be clean and well maintained. The centre was wheelchair accessible throughout, apart from a double door leading from a bedroom to the garden. This was kept locked for safety reasons due to previous attempts by a resident, who used a wheelchair, to exit the door independently. This had not been recognised as an environmental restriction at the time of the inspection. However, the inspector

viewed evidence that an occupational therapist was due to visit the premises to explore options to make this door accessible to the resident. Efforts had been made to personalise residents' bedrooms according to their individual tastes and preferences and residents had access to TV's and other multimedia devices, including subscription entertainment services if desired.

On the day of this inspection, the inspector did observe some meaningful interactions taking place with residents being offered activities such as a drive on the bus, listening to music and facial massage. One resident was seen to participate and take an interest in cooking a meal with the staff and there was evidence that residents participated in daily life in the centre by completing tasks that they had demonstrated an ability for, such as assisting with the dishwasher. Prior to the COVID-19 pandemic restrictions the annual review provided evidence that residents did participate in the community and were supported with ordinary lived experiences such as visiting the butchers and social farming. Some staff told the inspector of plans to take part in community events with residents when the restrictions lifted, but there was limited evidence to show that alternative activities and engagement with residents was being considered or tried at this time, with the physical and medical care needs of residents being the main focus within the staff team.

Visiting in the centre was restricted at the time of the inspection in line with public health guidance and government restrictions. However, residents were supported to maintain contact with family members through the use of video and phone calls.

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

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. This inspection found that although there had been some deficits in governance and oversight of the centre in the previous year, improvements were ongoing. Overall, this inspection demonstrated adequate capacity and capability of the provider to ensure the delivery of safe and effective services to the residents living in this centre. Some additional improvements were required in relation to the remit of the person in charge and staff training and development.

This was the second inspection of this centre since it had opened in 2018. A change in the management team of the centre had occurred since the previous inspection. The registered provider had appointed a person in charge of this centre. The person in charge reported to a community services manager and this person was present on the day of the inspection.

Residents were seen to be well cared for in this centre, and the person in charge demonstrated comprehensive knowledge of the residents and their support needs, and was committed to ensuring that these identified needs were met. The inspector had an opportunity to speak with the person in charge on a number of occasions throughout the day. She spoke in depth about the residents of the centre, occupied a clear presence in the centre and the inspector observed that residents and staff were familiar with her and relaxed in her company.
The community services manager was also present and told the inspector about the plans they had in place to improve the systems for oversight and support such as introducing a periodic service review and ensuring that regular quality conversations were taking place with the person in charge. The inspector viewed evidence that quality conversations, used to provide support and supervision to staff, had been taking place with the person in charge on a regular basis since November 2020. However, the inspector noted that, prior to this, these meetings were not occurring on a regular basis, and that there was little evidence to suggest the input of this individual prior to November 2020. A team meeting took place on the day of the inspection and the community services manager was seen to be in attendance at this.

The person in charge possessed the required qualifications and necessary experience for the role. She had remit over three designated centres and spoke about the challenges that this incurred and how she managed these challenges. A review of documentation indicated that there had been some deficits in governance and oversight arrangements in the previous year. For example, some actions identified in the annual review report compiled in May 2020 had not been completed within identified time-frames and some staff supervisions had not taken place in the previous year as required. The person in charge told the inspector that this was due to time constraints at that time as well as the difficulties presented by the COVID-19 pandemic. These issues had been identified by the provider prior to this inspection and the inspector found that there were good plans in place to address them, such as a proposed reduction in the remit of the community services manager, to allow greater time to spend dedicated to this centre, and the addition of a cluster support service staff member to provide administration assistance to persons in charge. The person in charge of the centre had in place action plans that aimed to address identified deficits and ensure full oversight of the centre was maintained going forward, and there were plans for these to be reviewed regularly by the community services manager.

Staffing levels in the centre were seen to be sufficient to meet the assessed support needs of the residents. There were three staff present in this centre during the day, and two at night. This centre was providing round-the-clock nursing supports to residents, all of whom required significant healthcare and personal care supports. One-to-one personal assistant hours normally provided by an external provider had not been replaced at the time of this inspection. This will be addressed in the quality and safety section of this report. The person in charge had identified that the staff team would benefit from the addition of a social care worker and plans were in place to introduce a suitably qualified individual into the team in the coming weeks.

Staff training records were viewed on the day of the inspection. The person in

charge had ensured that overall, staff had access to appropriate training, including refresher training. Some training that was required as per the organisations' own policies was overdue. For example, some nursing staff had not yet completed an in-house medicines management training for nurses. There was a gap in formal supervision that was not in line with the organisations policy. For example, documentation showed that one staff member had not taken part in formal supervision between June 2019 and November 2020. However, formal supervision in the form of quality conversations were now occurring in the centre. All staff had taken part in at least one quality conversation in the previous two months and the person in charge had a clear plan in place to ensure that these would be scheduled and completed going forward.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge of the designated centre. The person in charge had the required qualifications, skills and experience necessary for the role. The person in charge had remit over three designated centres. It was not evidenced that effective systems were in place to ensure full oversight of this centre given their overall governance role.

Judgment: Substantially compliant

Regulation 15: Staffing

The registered provider has ensured that there is a sufficient number of staff on duty in the centre to meet the residents assessed needs. The number, qualifications and skill mix of staff was appropriate and continuity of care was evident. There was a planned and actual staff rota in place and staff files contained the required information as specified in Schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training was being completed and staff had access to refresher training where required. Staff had received mandatory training in areas such as Safeguarding of vulnerable adults and fire safety. There was a gap in formal supervision that was not in line with the organisations policy but this had been addressed prior to the inspection taking place and formal supervision through quality conversations were now taking place for all staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had ensured that this designated centre was appropriately resourced to ensure the deliver of effective care and support. An annual review had been completed in 2020 and there was a clearly defined management structure in place. A review of documentation indicated that there had been some deficits in governance and oversight arrangements in the previous year. However, this had been identified prior to this inspection and there were clear plans in place to address these issues and improvements were already occurring as a result of the actions being taken.

Judgment: Compliant

Regulation 34: Complaints procedure

An up to date complaints policy was viewed in the centre, including an easy-to-read version. One complaint had not been resolved at the time of this inspection. The person in charge had escalated this as appropriate.

Judgment: Compliant

Quality and safety

Resident's wellbeing and healthcare needs were met by a good standard of evidence-based care and support. However, improvements were required in the areas of personal plans, and in the quality of interaction and choice of activities that residents were being offered to ensure that residents general welfare and development was being fully considered. Some minor improvements were also required to ensure that all risks were being appropriately reviewed.

The previous inspection had found that the registered provider had not ensured that each resident had access to facilities for recreation and all opportunities to participate in accordance with their individual interests, capacities and development needs. Some improvements had been made in this area and this was having a good impact on residents. For example, there were fewer peer-to-peer incidents occurring, one resident had started going out on the bus at least twice per day, as was their preference and there was evidence that prior to the COVID-19

pandemic residents had been accessing the community on a regular basis. However, further improvements were required in this area. Daily planners, as cited in the compliance plan submitted following the previous inspection, were not in regular use. Staff spoken to were aware of the importance of offering activities to residents regularly, but there was little evidence to show that there was ongoing efforts being made to try out, or identity, potential new activities for residents and staff reported that they did not always have time to offer activities to residients. The inspector saw that there was a clear need for this due to the curtailment of community based activities during the COVID-19 pandemic restrictions.

Due to COVID-19 restrictions in place some personal assistance supports provided to two residents by an external provider had not been in place since the beginning of the pandemic. The person in charge had identified that this was affecting the quality of life of these residents as they were now restricted in accessing the community as often, and also were not benefiting from the one-to-one interaction that these additional supports offered. This had been highlighted to the registered provider by the person in charge. There was documentation that indicated that the provider would allocate additional staff resources to cover this shortcoming. While the provider had for a period filled this role internally, this role had been vacant since August 2020. All staff spoken to confirmed that this was impacting on the quality of life of residents in the centre. The inspector was told that while staff tried hard to ensure that activities took place on a daily basis in the centre with all residents, this was not always possible. The inspector also viewed a complaint from the family of a resident about the withdrawal of this service.

Overall, risk management procedures in place in this centre were good and residents were safe in this centre. Risks were being identified and appropriately managed. For example, a risk associated with the storage of large amounts of oxygen in the centre had been identified and the person in charge had arranged for more appropriate storage arrangements. Some risk assessments and standard operating procedures had not been reviewed within identified time-frames.

The inspector viewed a sample of residents files and saw that they contained comprehensive information about residents, including detailed healthcare support plans. Personal plans in place had not been reviewed regularly and residents had not had annual visioning meetings in 2020. The person in charge confirmed to the inspector that goal setting and plans were not up to date. Some plans were in review at the time of this inspection and visioning meetings for two residents had taken place, with a further two scheduled for the weeks following the inspection. However, plans viewed by the inspector had not been updated to take into account changes in circumstances, such as the COVID-19 pandemic or the withdrawal of external personal assistance supports. There was evidence that some goal setting had last occurred in April 2020 for some residents and there was little evidence to show that goals were being set, reviewed or achieved. This meant that plans did not outline to staff the supports required to maximise the resident's personal development in accordance with his or her wishes and that actions were therefore not being taken to maximise the quality of lived experience for residents in the centre.

There was evidence that residents had access to numerous multidisciplinary supports as required, including appropriate medical input and occupational therapy supports. Support plans were in place for residents who had a percutaneous endoscopic gastrostomy (PEG), which is a procedure where a flexible feeding tube is inserted into the stomach and there was a nurse present in the centre at all times, including at night.

There were procedures in place to protect residents living in this centre from abuse. Staff and management spoken to had a good knowledge of safeguarding procedures and had received training in this area. Staff were seen and heard to support residents appropriately during the time the inspector was in the centre.

The registered provider had in place infection control measures that were in line with public health guidance and guidance published by the Health Information and Quality Authority (HIQA). Hand-washing and sanitisation facilities were available to staff and there was an adequate supply of hot water. The centre was observed to be clean and staff had received appropriate training in areas such as the donning and doffing of personal protective equipment (PPE) and hand hygiene. Staff were observed to wear PPE when attending to residents personal care needs.

Regulation 13: General welfare and development

The registered provider had not ensured that each resident had access to facilities for recreation and all opportunities to participate in accordance with their individual interests, capacities and development needs. While some improvements had been made since the previous inspection, further improvements were required. As discussed earlier in this report, the person in charge and staff present on the day of the inspection had identified that the withdrawal of personal assistance services to two residents was having a direct impact on residents, in that they were not being afforded the same amount of one-to-one interaction and opportunities for recreation. Although filled internally for a period, at the time of this inspection this role had been vacant since August 2020.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There was a 'Health, Safety and Risk Management' policy in place in the centre and this had been updated to reflect the COVID-19 pandemic. A risk register present in the centre identified a number of risks and the associated management plans and standard operating procedures to mitigate these identified risks, which included the storage of oxygen and a step leading from the double doors of a room occupied by a wheelchair user. Some of these had not been reviewed as per identified

timescales.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Plans in place had not been reviewed annually as required There was little evidence to demonstrate that goals were being set, reviewed or achieved.

Judgment: Not compliant

Regulation 6: Health care

Appropriate healthcare was provided in this centre. The person in charge had ensured that residents had access to an appropriate medical practitioner and recommended medical treatment, and access to health and social care professionals was facilitated as appropriate. Nursing care was provided to residents on a 24 hour basis.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans were in place where appropriate and staff had a good knowledge of how to best support residents to manage their behaviour. Since the previous inspection, peer-to-peer incidents had reduced significantly. Most restrictions in the centre had been identified and were being appropriately considered and managed. An environmental restriction was in place that prevented one resident from accessing the garden from their bedroom as desired had not been identified as a restrictive practice.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were found to be adequately protected from abuse on the day of this inspection. Staff had received appropriate training in relation to safeguarding

residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The residents living in the centre were supported to exercise choice and control over their daily lives where possible. For example, some residents were seen to mobilise independently throughout the house and enter and exit the building as they desired. Staff were knowledgeable about residents like and dislikes and were seen to facilitate these throughout the day. Staff were observed to speak to and interact respectfully with residents and were strong advocates for them. There was access to a variety of information in an accessible format and there were arrangements in place for access to external advocacy services if required.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had in place infection control measures that were in line with public health guidance and guidance published by the Health Information and Quality Authority (HIQA).

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 27: Protection against infection	Compliant

Compliance Plan for Country Lodge OSV-0005827

Inspection ID: MON-0031320

Date of inspection: 14/01/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Substantially Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:
The PIC is employed in full time position and has a remit over three SPC designated centres. The PIC is supported by PPIM in the management of her designated centres, PPIM is using a periodic service quality system and this system will be rolled out to her PICs. The PIC has assigned days to each of her centres and is present on all rosters.

The PIC and PPIM have developed a workplan for the three designated centres to ensure the PIC has oversight over all actions and a list of priorities. The PPIM and PIC discuss progress of the workplan at their monthly quality conversations. The PIC is also supported through monthly cluster meetings and the PPIM attending team meeting and annual review meetings in Country Lodge.

Since the inspection took place the PIC and PPIM have met with the Quality Manager and Director of Services on the 02.03.21 to discuss future planning for Country Lodge. Following actions were agreed to drive culture change within the staff team and develop a more person-centered service for the people supported:
• PIC and PPIM to schedule team meetings and address findings from HIQA inspections
• Discuss responsibilities and expectations moving forward
• Develop action plans with the staff team to address development of person centred planning and ensure oversight of progression
• The PIC to plan time scheduled in the centre weekly
• The PPIM to work from the centre for a half day weekly

The PIC and PPIM have completed a team meeting on the 10.03.21 and scheduled to meet further team members on the 16.03.21 to discuss delegated duties, accountability and responsibility and expectations.

SPC Quality Conversations policy is currently under review. It was agreed with the Director of Services at the meeting on the 02.03.2021 to proceed with the new

timeframes of the updated QC policy which involves holding quality conversations with individual staff quarterly. Each staff member will have an action plan following same, review of action plans will take place monthly. The PIC will assign this duty to members of team such as SCW or staff nurse, and PIC will meet with SCW and staff nurse monthly to review action plans.

To help the PIC and staff team keep an overlook on action plans, PIC is currently developing a house folder for action plans, so all involved can have easy access to their actions and document progression on same.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Since the inspection took place the PIC has ensured completion of outstanding Quality Conversations in Country Lodge. Training needs are discussed at team meetings and also as part quality conversations to ensure completion of mandatory and house specific training and refresher training.

The PIC and PPIM have undertaken a review of the current staff team and skill mix in Country Lodge. To ensure a better skill mix in the house 2 SCW have been redeployed since the 26/02/2021 to Country Lodge in order to facilitate and support the development within the team regarding person centred planning for the people supported.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
At present SPC is actively recruiting for a PA position to ensure 1:1 support for a person supported in Country Lodge at certain times. An interim plan was put in place until recruitment is completed successfully. From the 15.03.2021 onwards designated PA hours will be facilitated by staff from SPC Community Hub and also within Country Lodge staff team roster to ensure the person supported can avail of her personal time and interests.

To develop the understanding within the team the PIC and PPIM have scheduled

meetings for the 10.3.2021 and 16.03.2021 to discuss persons supported access to facilities for recreation and opportunities for community participation. These meetings are the starting point for review of forward planning within Country Lodge to ensure all persons supported have meaningful days where individual interests and skills development are the focus.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC has delegated the review of risk assessments to staff members to ensure a full review of the centres risk register. Risk assessments will be reviewed as part of each person's monthly review meetings within their personal plan and the centre's risk register will be updated accordingly.

The PIC will oversee the risk management planning for Country Lodge through actions plan reviews, Quality Conversations and person's monthly review meetings.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Since the inspection all people supported have had their annual reviews as per SPC Personal Plan Framework and annual review and visioning meetings have also been scheduled for each person for 2021 to plan the year ahead.

Roles and goals have been identified. Progression of same is documented within the weekly progress sheets and reviewed on a monthly basis as part of person's monthly review meetings. The PIC monitors documentation and evidence of progression through staff teams action plans and monthly feedback from designated staff members.

Moving forward, team meetings being held will include discussion on people supported's participation in the community, review of meaningful day ensuring their capacities, independence and developmental needs are the focal point.

Weekly residents' meetings are taking place in Country Lodge to ensure the review of Goals and roles for people supported and use of technology at these meetings and use of

easy read policy to support people supported take part in these meetings.

The staff team can avail of the Quality manager to attend meetings in Country Lodge to provide mentoring and support. The Quality Manager is scheduled to attend the next team meeting in Country Lodge on the 21/04/2021.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
On the day of the inspection a restrictive practice regarding patio doors in one person's bedroom has been identified. Documentation in line with SPC policy has been completed by the PIC and staff team and is available in persons file and house folder.

Necessary amendments to the premises were discussed at SPC housing and facilities meeting on the 03.03.21 and agreed to make the necessary changes to the premises to ensure person supported has free access to the garden from the bedroom. H & S department confirmed on the 18.03.2021 that a builder has been involved to ensure necessary amendments are being completed in a safe way. The works are to be finalised latest by 30.05.2021.

A new Behaviour Support Specialist has commenced work in SPC on 01/03/2021. Quality Department has set up a working group with a CSM, PIC and Behaviour Support Specialist now to complete a full review of SPC Policy on Restrictive Practices. The working group is meeting on the 19.03.2021 to complete the HIQA Self-Assessment tool for Restrictive Practices and develop from identified actions the new policy for the service.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/03/2021
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/03/2021
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance,	Substantially Compliant	Yellow	30/03/2021

	operational management and administration of the designated centres concerned.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	10/04/2021
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.	Substantially Compliant	Yellow	30/03/2021
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	10/04/2021
Regulation 05(6)(a)	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	Not Compliant	Orange	10/04/2021

	needs or circumstances, which review shall be multidisciplinary.			
Regulation 05(6)(b)	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 needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	10/04/2021
Regulation 05(6)(c)	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 needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	10/04/2021
Regulation 05(6)(d)	The person in charge shall ensure that the	Not Compliant	Orange	10/04/2021

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/05/2021