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:	Skylark 5
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	12 August 2021
Centre ID:	OSV-0007938
Fieldwork ID:	MON-0032884

About the designated centre

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

Skylark 5 is a full-time residential service intended to meet the care and support needs of three adults with a primary diagnosis of intellectual disability. The purpose of Skylark 5 is to make every effort to provide each resident with a safe, homely environment which promotes independence and quality care based on the individual needs and requirements of each person. The centre aims to support residents for as long as they wish to remain in the centre. The centre is staffed at all times.
Skylark 5 has access to the Brothers of Charity Services Ireland multidisciplinary team to assist with individual assessments and ongoing needs as required. Each individual has a community based GP. Staff provide support to residents to engage in in-house activities in line with their preferences, ability, health and the requirements of infection control and prevention. Community based activities are risk assessed for safety and supported in line with Public Health guidance. Skylark 5 does not pay for any activities for persons supported. Each individual will pay for any activity that they choose to partake in.
The centre comprises two houses in short walking distance from each other. They are located in a suburb of Limerick city. A number of shops, restaurants, a cinema and access to public transport are within walking distance of the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 12 August 2021	09:20hrs to 17:55hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

This was an unannounced inspection of a newly registered centre. Overall residents were supported to have a good quality of life and were settling in well to their new homes. The support provided was of a high standard. Some improvements were required to ensure that relevant documents and assessments were reviewed and updated to reflect residents' current needs and the recent move. Some elements of the fire safety management systems required review to ensure residents' and staff safety.

This was the first HIQA (Health Information and Quality Authority) inspection of this centre. The centre was first registered in April 2021 and at the time of this inspection the three residents had been living there for eight weeks. The centre comprised two houses in an estate on the outskirts of Limerick city. Two residents lived in one house and one resident lived alone in the other. Although the houses were a short walking distance from each other, the residents did not socialise with each other and the staffing groups were entirely separate. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

When the inspector arrived, there was a staff member from a local day service, operated by the same provider, in the centre. It was explained that as day services had not yet re-opened for those living in residential centres, one staff member had been allocated to each house to support all three residents to participate in activities. There was one staff member in each house at all times. Residential staff were rostered to do sleepover shifts during the week, with day service staff working from 09:00 to 16:30 from Monday to Friday. A residential staff member worked in the house from Friday afternoon until the following Monday morning. Staff working in both houses had worked with the residents in their previous placements and knew them well. Staff spoke with the inspector about residents' interests, personalities, what was important to them, and their support needs. This person-centred knowledge and the level of staff continuity was a support to the residents as they settled into their new homes and got to know the person in charge and other management staff. All interactions observed were respectful and warm. It was evident that positive relationships existed between the residents and the staff supporting them.

The inspector met with all three residents living in the centre. Two residents had also lived together for a few months in another centre prior to the move to Skylark 5. Both residents were in bed when the inspector arrived, with one later saying that the doorbell had woken them up. Residents had a routine in place that was familiar to them and staff. Both residents appeared at ease in their home and comfortable with each other and the staff supporting them. They ate breakfast together and were aware of an outing planned for that day. They were positive about their new home and staff when speaking with the inspector. It was evident that they were

getting to know the local area. They had been to the local pub for food and looked forward to returning. One resident also referred to the local shopping centre. They were familiar with the person in charge and appeared happy for them to visit their home. One resident liked to prepare a list of things to discuss with the person in charge and it was evident that items on previous lists had been addressed. Both residents were interested in sport and spoke about going to matches, watching them on television and the upcoming All Ireland hurling final. One resident was looking forward to participating in sports again as they had previously enjoyed golf and horse riding. The residents later went shopping and out for lunch. Towards the end of the inspection, they were going to a local supermarket. One of the residents was assessed as requiring full-time supervision. As there was only one staff member rostered to work in the house, this meant that both residents had to participate in all community based activities and outings together. To date, this hadn't posed a challenge, however one resident was overheard asking if they could stay in the car rather than go into the shop. Management informed the inspector that there were plans to assess the ability of this resident to stay in the centre alone, if they wished. It was agreed that the staffing requirements to meet the needs of the residents in this house would need to be kept under review.

Later, the inspector met with the resident who lived alone. This resident clearly took pride in their home and was happy to speak with the inspector about their collections and photographs on display throughout the house. As this resident lived alone they had a room upstairs that they used to store some of their books and other preferred things. They spoke about going for a walk earlier that day, their family and their favourite member of the staff team. This resident was very interested in cooking and discussed plans to make a cheesecake in the coming days. Staff told the inspector that this resident liked to get involved in some of the everyday activities in the house, such as emptying the dishwasher.

Both houses were recently built and had the same internal layout. The houses were observed to be clean and decorated in a homely manner. Each house had been personalised to reflect the tastes and interests of the people living there. This was evident in the pictures and decorations on display and in the furniture that had been bought. There was a kitchen and dining area which was linked to a living room that could be closed off using double doors, if residents wished. One resident had a bedroom with an ensuite bathroom in each house. In the shared house, the other resident had the exclusive use of the upstairs bathroom. There were gardens to the rear of each house that were accessed from the kitchen area. As both houses were mid-terrace, the back garden was an enclosed space. Emergency fire exit signs were installed above the doors to each garden. The inspector asked that these, and the designated assembly points, be reviewed by a competent person to ensure that they were safe locations to bring residents to, should an evacuation be required in the event of fire. The doors in the downstairs communal areas were fitted with fire door retainers linked to the alarm system, these allowed doors to be kept open and ensured they would close should the alarm sound. One resident had requested these be installed upstairs in their home. Plans were underway for this request to be accommodated. However, when in that house the inspector found that a basket was in place to prevent one fire door closing. This would mean that if required in the event of a fire, the door would not be an effective containment measure. The basket

was removed immediately.

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 to each resident living in the centre.

Capacity and capability

Overall, good management practices were in place. The provider adequately resourced and staffed the centre, and systems had been developed to collect information in order to drive service improvement. There was some more work to be done in ensuring that the assessments and documentation reflected this centre and residents' current needs.

There was a clear reporting structure in the centre. The social care workers reported to the person in charge who reported to the area manager, who was also a person participating in the management of the centre. As day service staff worked alone daily in both houses, the inspector asked for clarity on the reporting structures in place. The person in charge described the lines of accountability and how, if required, they raised any issues regarding the service provided by these staff while working in the centre. As the centre was registered in April 2021, an annual review and six-monthly unannounced visits (which are required by the regulations) had yet to be completed. The person in charge described a range of regular audits that were in place to monitor various aspects of the support provided in the centre. Although the centre comprised two houses, the staff teams were entirely separate. Therefore the person in charge arranged for separate team meetings for each house. Quarterly, one-to-one staff supervision sessions had also begun.

The person in charge also fulfilled this role for one other designated centre and another residential service that consisted of six apartments where 10 people lived. The person participating in management informed the inspector that in the coming weeks the person in charge would no longer be responsible for the other designated centre. This was a welcome update given their large remit. Neither the area manager nor the person in charge had worked with these residents before the recent move. It was evident throughout the inspection that they had developed relationships with each resident and were continuing their efforts to establish a positive rapport with them all.

As will be outlined in the next section of the report, not all of the documentation relating to residents' care and support had been updated to reflect their recent move into the centre. It was evident that there was a system in place for this to be completed and was almost fully complete for two of the three residents. Efforts to address this had also been hampered with delays in getting appropriate IT (information technology) systems running in the two houses. The person in charge informed the inspector of the documentation systems they were planning to

introduce so as to ensure that staff were able to easily access the most up-to-date information and to address the duplication of some key documents.

While all three residents had a written service agreement with the provider, one did not reflect the recent move to this centre and had not been signed. It was also noted that a staff member employed by the provider had signed residents' service agreements in the space allocated to the resident's representative or advocate.

The person in charge is required to submit quarterly notifications to HIQA in relation to specific incidents, including the use of restrictive practices. Despite their use in this centre, no such notifications were submitted for the second quarter of 2021. The residents moved into the centre in the middle of June and this notification would therefore have only covered a two-week period. The person in charge advised that all of the required information would be submitted for the next three month period. While a restrictive practice log was in place for one of the houses, it had not yet been competed for the other. The person in charge advised that all restrictive practices were reviewed every three months, in line with the organisation's policy.

Staff training records were reviewed. Due to public health guidance related to the COVID-19 pandemic, not all training had occurred as planned. The provider had arranged for some training to be completed online. This included training in fire safety. At the time of this inspection one staff member was required to attend this refresher training. The person in charge advised that as part of the on-site induction for staff, they gave guidance regarding the site-specific systems in place including the various escape routes and the fire detection and alarm systems installed. Two staff required refresher training in the administration of medication, management assured the inspector that this training would be provided in August and September 2021.

Regulation 14: Persons in charge

The person in charge had the qualifications, skills and experience necessary to fulfil the role.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of the staff was appropriate to the needs of the residents at the time of this inspection. There was a planned and actual rota in place. Residents received a continuity of care and support from the staff team, many of whom had worked with them where they lived prior to moving to this centre.

Judgment: Compliant

Regulation 16: Training and staff development

Two staff required training in medication management which was scheduled to be completed within three weeks of this inspection. One staff required refresher training in fire safety.

Judgment: Substantially compliant

Regulation 21: Records

Each resident's personal plan did not reflect their recent move to this centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre. Management systems were in place to ensure the service provided was safe, consistent, appropriate to residents' needs and monitored. Staff were regularly meeting with members of the management team and staff meetings and one-to-one supervision sessions had begun. As the centre was first registered in April 2021, an annual review or six-monthly visit had not yet taken place.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Residents had been given the opportunity to visit the centre prior to moving in. All residents had a written agreement with the provider however one of these was not specific to this centre and was not signed.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all occasions where a restrictive procedure was used in the centre were reported to the chief inspector, as is required by the regulations.

Judgment: Not compliant

Quality and safety

The inspector found that the quality and safety of care and support provided was of a good standard. The inspector's interactions and observations, as well as a review of documentation, indicated that residents enjoyed living in this centre where their rights were promoted. Residents received person-centred care that supported them to be involved in activities that they enjoyed, to maintain the relationships that were important to them, and encouraged involvement in their local community. Some of the documentation and healthcare plans in residents' personal plans required review. Risk assessments and elements of fire safety management also required review to ensure residents' safety in their homes.

The inspector reviewed the personal plans of all three residents. While all of the information required for staff to support residents was available, not all of it had been updated to reflect the recent move to this centre. It was also identified that several copies of some documents were in files and it was not always clear which was the most recent one for staff to follow. In addition, some healthcare plans had not been reviewed in the last 12 months and therefore did not reflect recent interventions to address these issues. It was noted that previous reviews of healthcare plans had not included an assessment of the effectiveness of the plan. There was evidence that all three residents had input from multidisciplinary professionals, as needed.

Each resident had completed a person centred plan which outlined the goals that were important to them to achieve throughout the year. The impact of the COVID-19 pandemic was evident, with all residents expressing a wish to return to spending time with, and visiting, family members. There was evidence that progress had been made in supporting the residents to achieve their goals. When reviewing one plan it was identified that one resident had gone on holiday, supported by a staff member. As well as the costs of accommodation, the resident had also paid for the staff member's meals. When this was questioned, management advised that it is the organisation's policy that accommodation costs are covered but assured the inspector that the resident would be refunded the cost of staff meals.

There was a clear focus in the centre in supporting residents to be active in their community. While the pandemic had limited the availability of some community based activities, it was planned for residents to return to sporting activities and

cooking classes. Until that was possible, staff were supporting residents to go out to become familiar with the local area. Family contact was very important to all three residents and records reviewed documented how this was supported.

Residents' healthcare needs were well met in the centre. There were records of recent visits to their general practitioners and other allied health professionals. Residents had also been supported to attend specialist medical appointments, as required, and to participate in a national screening programme.

All residents, who required one, had a recently reviewed behaviour support plan. Staff appeared familiar with these plans and had signed to confirm that they had read them. There was evidence of regular visits to these residents, and input at multidisciplinary meetings, from psychology and behaviour support staff.

The inspector reviewed individual risk registers for each of the residents. While these were comprehensive, it was not always possible to identify when they were last reviewed or the current risk rating. These required review to ensure that they were accurate and reflective of the current situation. The person in charge spoke to the inspector about a risk assessment that was in progress. It was discussed that as well as assessing the risk posed by a particular behaviour to staff, the risk to the resident involved would also be assessed so as to document the protective measures that the provider had implemented.

The centre was equipped with fire detection and alarm systems and firefighting equipment. These had been installed by a competent person. Staff were completing daily and weekly checks as part of fire safety management in the centre. As a result it had been identified that some of the door retainers required replacement. Where these were not working effectively, fire doors remained closed. There was evidence that evacuation drills had been completed and each resident had a personal emergency evacuation plan (PEEP). The support requirements of residents at the assembly point was not included in their PEEPs. This was especially relevant to this centre as one resident had been assessed as requiring one-to-one supervision at all times and only one staff member worked in each house at a time. The back gardens and other identified assembly points also required review to ensure they were safe locations to bring residents to, should an evacuation be required. As outlined in the first section of this report, a fire door in one of the houses was being kept open with a basket, thereby making it ineffective as a containment measure. This was addressed immediately.

Regulation 10: Communication

Residents were supported to communicate in line with their preferences and abilities. Residents had access to telephones, televisions and wireless internet in the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Each resident had access to and control of their belongings. Staff were in the process of supporting two residents to open their own bank accounts.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were provided with opportunities to participate in recreational activities and were encouraged to get involved in day-to-day activities in their homes. In the absence of a day service, day service staff were allocated to each house. Staff were supporting residents to get to know their new local area.

Judgment: Compliant

Regulation 17: Premises

The houses were newly built and had been decorated in a homely manner in line with the residents' tastes. There was adequate space and storage facilities available. Each resident had the exclusive use of a bathroom in their home and could freely access the laundry facilities.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk register required review to ensure that it was reflective of the current hazards and the risks they posed.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19. A system of enhanced cleaning was in place. Staff were observed taking their own and residents' temperatures, wearing masks, washing their hands regularly and using hand sanitizers. Residents were aware of the need to wear masks when accessing some services in the community.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable fire detection and alarm systems and equipment were available in the centre. Drills had been completed in both houses. All residents had a recently reviewed PEEP in place. Due to the assessed needs of one of the residents, the support required at the assembly point needed to be included in this document. As one of the escape routes in each house led to an enclosed garden, the assembly points required review to ensure that they were safe locations. One fire door in the centre was kept open with a basket. This was immediately addressed during the inspection. One staff member required refresher training in fire safety.This was addressed under Regulation 16.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of the health, personal and social care needs of each resident had been completed. Each resident had a personal plan. Not all elements of the plans had been reviewed in the last 12 months, as is required by the regulations. It was not documented if the effectiveness of healthcare plans had been assessed.

Judgment: Substantially compliant

Regulation 6: Health care

Healthcare was provided in line with residents' assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

All residents, who required one, had a recently reviewed behaviour support plan in place. At the time of this inspection, a restrictive procedure was to be introduced for one resident. Their written consent to this was documented in the centre.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to protect residents from abuse. There were no investigations in relation to alleged or suspected abuse underway in the centre at the time of this inspection. All staff had attended training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were encouraged and supported to exercise control in their daily lives. Where assessed as necessary, risk assessments and multidisciplinary input were provided to support individual choices. Residents had access to advocacy services and were consulted in the running of the centre.

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	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Skylark 5 OSV-0007938

Inspection ID: MON-0032884

Date of inspection: 12/08/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The two staff members that were scheduled to attend medication management training completed this training on the 23/08/2021 and the 31/08/2021. • The relief staff member identified as due for refresher fire safety training has been booked in with the training department for the 20/10/2021. • The PIC will review training records on sims quarterly and refer to the training department when training needs has been identified.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The PIC and Keyworker reviewed the residents Person Centered Plans. Updates reflect the change of address, however additional updates capturing new goals identified since the move are still work in progress. • Personal Centered planning meeting with some team members was held on the 7/09/2021. The aim is to have the residents Personal Centered plans completed by September 2021. • MY Profile My Plan folders have been reviewed by the PIC and duplicated documents have been archived.	

• The organisation's process for the Annual Review is formulated at the end of each year and will be submitted by March the follow year. • PCP training for all PICS and PPIMS will be rolled out in Q4 2021.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • The services agreements missing on the day of the inspection has been reviewed and signed by the residents and PIC. The individual service agreement was signed and filed in the residents My Profile My Plan. Completed on the 15/08/2021. • In the event of the residents not capable of giving consent for the terms on which that residents shall reside in the Designated Centre, the organisation has agreed to link in with Advocacy to review independent advocates to support this process when required.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • The residents moved into their new home two weeks prior the submission of quarterly notifications to HIQA. As this move was mid transition it was agreed locally for the former PIC's will complete the quarterly notifications, however this resulted in a gap between the notifications for the new designated Centre. Therefore for the purpose of this Compliance plan the PIC has submitted the notification on the HIQA portal relevant to the second quarter. • The PIC added this item to the agenda of the PIC/AM meeting, requesting that both PIC's have access to the HIQA portal and OLIS for a short period to prevent gap between transitioning from both designated Centre's. • A Restrictive Practice log for all residents have been devised and placed in the individual's files.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The risk register was reviewed and updated by the PIC ensuring all risks have a review date and a clear risk rating distinguished.

• The PIC implemented a risk assessemt for the residents documenting the protective measures and assessing the risk posed by a particular behaviour to staff.

• The PIC has linked in with a member of the Behaviour support team (BST) to request a refresher training day for "working with people with behaviours that challenge and poor mental health. Training scheduled for Novermebr 2021.

• On the day of the the unannounced inspection the inspector observed that the staff office/bedroom was locked and requested a restricve practise be put in place. The restrictive practise discussed at an MDT held on the 01/09/2021. The decision of the MDT following their review, guided by the policy, was that this was not a restrictive practice.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• In the event of a fire the assessed needs of one of the residents once he reached the assemble point has been discussed with the team. The residents PEEP was amended to reflect supports required during a full evaluation. The PEEP's was updated by the PIC on the 03/09/2021.

• Planning permission for the dwellings was granted by the Limerick County Council. It is standard practice for mid terrace houses to evacuate via the neighbors properties. The fire station have been informed of the new premises and they have been provided with copies of the drawings for the houses to be held on file.

• A visit from the Fire safety officer will be arranged to review the fire assembly points. Any recommendations will be followed.

• Team meeting held 15/08/2021 to address the basket holding the door opened. During the PIC's house visits this method of keeping the door opened will be closely monitored, in the event of this matter reoccurring a risk assessment will be developed.

• The fire safety engineer has been requested to carry out a review and issue a letter

which will be shared with HIQA as requested in respect of fire safety.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • The importance of identifying goals that are specific and person centered will be added to the agenda for discussion with staff as part of the next staff meeting. • The person in charge will ensure that the goals identified in the assessment of needs for each resident will be more specific and person centered by using the SMART tool to effectively monitor the status of each goal. • The PIC and Keyworker reviewed the residents Person Centered Plan. Amendments were made to reflect the change of address. • Personal Centered planning meeting was held on the 7/09/2021 to discuss the individual's person centered goals and capture new goals identified since the move. • The person in charge completed the first of a two part training on Understanding the difference between the Person Centered Plan and Personalised Care and Supports Plans on 01/07/20. The second part of this training is scheduled for the 14/09/2021. • In addition to the above training the PIC has planned to attend the BOCL two half day training course on Person Centered Planning. This training is scheduled for the 02/11/2021 + 05/11/2021. PPIM will also attend this training during Q4 2021	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	20/10/2021
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/09/2021
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the	Substantially Compliant	Yellow	15/08/2021

	terms on which that resident shall reside in the designated centre.			
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	23/08/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/10/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	10/10/2021
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	Not Compliant	Orange	08/09/2021

	including physical, chemical or environmental restraint was used.			
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.	Substantially Compliant	Yellow	05/11/2021
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/09/2021