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:	B Middle Third
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	23 March 2022
Centre ID:	OSV-0003719
Fieldwork ID:	MON-0036565

About the designated centre

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

B Middle Third is a community based semi-independent residential house operated by St. Michael's House. The designated centre provides services for residents with an intellectual disability and other needs. Residents are supported to become as independent as possible whilst living here. This service supports people over 18 years of age for up to two residents. The centre is situated in a suburban area close to a range of community amenities and public transport. The premises consists of a two bedroom bungalow with a kitchen/dining room, a sitting room and two bathrooms. A small garden area is available to the front, with a larger one located to the rear of the premises. The centre operates a Social Care model and is staffed by social care workers. Staff encourage residents to be active members in their communities and to sustain good relationships with their family and friends. Staff are primarily available to support the residents in the evening period and at weekends. Outside of these times, if required, residents can utilise an on-call facility or make contact with staff in another centre in their locality.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Wednesday 23 March 2022	15:10hrs to 21:10hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This was an unannounced risk inspection subsequent to receipt of information regarding safeguarding concerns and poor transition planning in the designated centre. In line with public health guidance, the inspector wore personal protective equipment (PPE) and maintained physical distancing as much as possible during interactions with residents and staff. The inspector had the opportunity to meet with both of the residents on the day of inspection. The inspector used conversations with the residents and key staff as well as a review of documentation to form judgments on the quality of residents' lives in the designated centre.

Both residents were eager to meet with the inspector to discuss recent proposals for alternative accommodation. One resident told the inspector that, due to recent conflict between the residents, they had been advised by the provider they would both be moving out to alternative housing. This resident told the inspector that they felt that they were being blamed for recent conflict and that they had not been consulted with fully regarding the move. The resident stated that they had not been told where they were moving to or when the move was taking place. The inspector saw that this resident had commenced packing their belongings. This resident stated that they had attended meetings regarding the move however their family had not been at these meetings. The resident said that they wanted to live independently and did not want to live with other people.

The other resident told the inspector that life had been very difficult for them in the designated centre over the past year. The resident was tearful when describing the issues in the centre and their feelings about the proposed move. The resident stated that they would like to live on their own and that they had the ability to do this. They said that they had told the provider for a long time that this was their goal. The inspector saw that this goal was reflected in the resident's file and that, based on their assessment of need, they had the skills and capacity to live independently.

The resident described conflict with the other resident and told the inspector about incidents where the other resident had asked them to do household chores for them or assist them in activities of daily living. The resident said that it was hard to say no to the other resident and that they had told the staff this. The dynamic in the centre appeared to be impacting on this resident's right to privacy and to personal relationships as they told the inspector that they were unable to have their partner over for dinner as the other resident would not allow this. While the resident stated that they did want their own place to live, they said they were shocked to be told last week that they were moving out. The resident said they did not know where they were moving to or when the move was taking place. They were adamant that they did not want to live with other people or in a centre that was staffed full time

Staff informed the inspector that the peer compatibility issues were having significant impact on the residents, with one resident being more impacted than the other. Staff described how one resident could exert control over the way in which

the centre was run. This resident had objected to particular staff coming in to the house and to staff assistance with household tasks. The resident had also objected to the other resident having protected one to one time with staff and had become agitated when the resident chose to spend time with staff rather than with them. Staff described, and had documented, incidents of physical and psychological abuse predominantly from one resident towards the other.

The inspector saw that one resident cooked dinner for both residents on the day of inspection. Staff informed the inspector that the resident who had not cooked was unhappy with how dinner had been prepared. In order to diffuse the situation, the resident who had cooked the dinner chose to eat in her bedroom. The inspector saw documentation of further incidents where this resident had to isolate in their bedroom or leave the house due to negative interactions with the other resident.

Overall, the inspector saw that there were significant peer compatibility issues which were impacting on residents' health and well-being and rights. These compatibility issues also presented a safeguarding risk with incidents of physical and psychological abuse documented. The inspector met both residents who were articulate and able to describe the events of the past 12 months. Both residents were anxious and distressed regarding the news that they would be moving house. They were unaware of the transition process or of a plan for where and when they would be moving.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the inspector found that the provider was not demonstrating that they had the capacity and capability to provide a safe service to all residents. The findings from this inspection demonstrated that the provider had failed to put appropriate arrangements in place to ensure themselves that a quality and safe service was being delivered. The provider's failure to do this resulted in a service where multiple deficits were identified. The inspector was not assured that residents were receiving a safe and effective service that was meeting their individual needs. There was a failure on the behalf of the provider to respond to safeguarding concerns in a timely manner and to implement effective safeguarding plans. This resulted in a prolonged period of time where residents were subjected to psychological and physical abuse. For this reason, a provider warning meeting was held with the provider subsequent to the inspection. A warning letter was issued and the provider was required to respond in writing detailing how they propose to bring the centre into compliance. This was in progress at the time of writing the report. This report will set out the

findings and areas of significant non-compliance which led to this regulatory activity.

The inspection was unannounced and occurred on receipt of solicited information of concern. The purpose of the inspection was to focus on key regulations related to the information of concern. These included governance and management, safeguarding, residents' rights and transition or discharge planning.

The inspector was not assured that there were adequate mechanisms in place to ensure effective provider oversight of the designated centre. The centre's statement of purpose was out of date and did not accurately reflect the staffing whole time equivalent for the designated centre. Additionally, care and support was not being delivered as set out in the statement of purpose. For example, the statement of purpose stated that monthly resident meetings were to be held. However, the inspector was informed that these did not take place and that residents chose individual keyworker meetings instead. There were no records maintained of these meetings and so it was not possible to verify that these had occured.

There was no roster maintained for the designated centre and the staffing complement was allocated from another designated centre's roster. It was therefore not possible to verify what staffing hours were being provided or actually worked in the centre. A key element of the provider's safeguarding plan was to ensure staff were in the centre in the afternoons when residents were together. However, without an actual roster it was not possible to verify that this safeguarding measure was in place.

The provider had implemented a series of audits to support oversight of the designated centre including monthly data reports, bi-annual reviews and an annual review of the quality and safety of care. However, the inspector found that audits were not completed consistently and did not comprehensively set out time -bound plans to address presenting risks. For example, the inspector saw that monthly data reports were in place for the centre. These reports provided information on incidents, complaints, staffing and other pertinent risks in the centre. On review, of these reports, the inspector found that they had not been completed since August 2021. It was therefore not clear how the provider was monitoring the safety and quality of care in the centre on a regular basis and, furthermore, how risks were being reviewed and escalated to the provider as required.

The annual review was not maintained in the designated centre. A soft copy was furnished to the inspector the day following the inspection. The inspector saw that the annual review reflected some of the issues presenting in the designated centre. For example, residents reported "I need more private time" and "staff don't listen sometimes". Staff had also highlighted through the annual review that safeguarding and compatibility issues had escalated and that staff wanted to support residents to live more independently. A six monthly review completed in August 2021 also noted peer compatibility issues. However, both of these audits failed to set out a specific, measurable and time-bound action plan to address the safeguarding and compatibility issues. This demonstrated that, while audits were in place, they were not being used as a tool to drive service improvement or to escalate and respond to

known risks.

Regulation 15: Staffing

There was no planned or actual roster maintained specifically for the designated centre, with staff hours coming from another designated centre's roster. It was therefore not clear that staffing levels and skill mix were appropriate to the assessed needs of residents.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had failed to ensure that the service being provided in the designated centre was safe, appropriate and effectively meeting the needs of the residents. Known areas of concern in relation to safeguarding and peer compatibility issues had not been addressed in a timely manner. This left residents at risk of abuse over a prolonged period of time.

There were ineffective management systems in place in the designated centre to ensure that the service provided was safe and was being consistently and effectively monitored. The designated centre was not resourced in line with the statement of purpose. While the provider had mechanisms in place to support oversight of the designated centre including monthly data reports, annual reviews and six monthly audits, these were not used as tools to drive service improvement and to respond to known risks. Action plans developed from these reviews were not reflective of areas of concern identified through audits.

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The centre's statement of purpose was out of date. It did not accurately reflect the whole time equivalent staffing levels for the designated centre. Additionally, mechanisms to support residents in making choices regarding the day to day

running of the centre as set out in the statement of purpose were not in place. The inspector was informed that residents chose not to have resident meetings, and instead, had one-to-one meetings with keyworkers. Records of these meetings were not maintained and it was therefore unclear how the provider was facilitating residents in having choice and control over the running of the centre.

Judgment: Not compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspector was not assured that residents were in receipt of a quality service or that the service was managed in a way that responded to risk in a timely manner. Resulting from this, the inspector had significant concerns regarding the safeguarding and wellbeing of residents living in B Middle Third. Arrangements to protect residents from abuse were found to be ineffective and consequently an immediate action was issued on the day of inspection in relation to safeguarding. An urgent action plan was issued the day following the inspection relating to the resourcing of the centre.

The inspector saw that there had been multiple incidents of peer-to-peer verbal and physical abuse recorded in the designated centre. Not all of these incidents were notified to the Chief Inspector as required by the regulations or to the local safeguarding team. The safeguarding documentation and records in the centre were not adequately maintained. Many incidents were not recorded on incident report forms but were typed by staff and stored in a separate folder. Some of these were not signed or dated. This meant that practices around incident recording and reporting were inconsistent. The impact of this was that the provider was unable to adequately assess the frequency and impact of safeguarding events.

Where incidents of abuse had been reported, the provider had implemented safeguarding plans. However, these were ineffective as peer-to-peer incidents of abuse continued to occur on a regular and more frequently occurring basis. Residents spoke about the impact of abuse on their wellbeing and described times when they had to isolate in their bedroom or leave the centre due to abuse. The impact of abuse on the residents was documented by staff, with one resident having informed staff on multiple incidents that they "can't cope anymore". This resident told staff that they were very hurt and that they felt that nothing was being done about the abuse.

There was evidence that the provider was aware of the abuse as far back as February 2021 when a multi-disciplinary meeting documented safeguarding and resident compatibility issues. A more recent multi-disciplinary (ICM) meeting in January 2022 stated that the peer-to-peer incidents constituted possible domestic or psychological abuse with elements which were controlling or coercive. The person in

charge had escalated concerns to senior management in writing in January 2022 which highlighted that the current safeguarding plan was ineffective. In spite of being aware of the abuse, the provider had failed to discharge their responsibility to safeguard residents. The impact of this was that residents were subjected to incidences of peer-to-peer abuse which were distressing to them and impacted their rights over a prolonged period of time.

The provider's safeguarding plan set out that a strategy to reduce peer-to-peer incidents was to review the housing arrangements and support one resident to live independently as per their assessed needs. However, there was an absence of a comprehensive transition plan which was discussed, safe and agreed with the residents and their representatives. The provider had recently informed both residents that they were to move to alternative centres. It was unclear what criteria this move was based on and how this was being planned in a manner in accordance with residents' needs. Residents were upset regarding this move and, in particular, the absence of a plan. Both residents had begun to pack their belongings however they did not know where or when they would be moving.

The inspector was informed by a service manager that alternative designated centres had been identified however these were group houses. Both residents told the inspector that they did not wish to live with other people and this was further documented in one resident's assessment of need and care plans. A move to group houses would therefore have not been in line with their preferences and for one resident, their assessed needs. The inspector reviewed both residents' assessments of need and care plans and saw that one resident had been assessed as having capacity to live independently. It was documented in this assessment of need that the resident was very unhappy in their current living arrangement and that their mental health had been impacted by the peer compatibility issues. There was a lack of comprehensive care plans to support these identified needs. The resident's goal was to live independently in an apartment. The inspector saw that the provider had made referrals to both external housing agencies and to their internal referrals committee in this regard, however, these had not progressed.

The inspector saw that the other resident's assessment of need had been recently reviewed however it also did not comprehensively and consistently reflect the resident's needs. For example, the assessment of need stated that the resident did not require support with expressing and understanding their feelings however it subsequently set out that the resident attended psychology for support with emotions. The resident's mental health needs were also not clearly assessed and documented. It was reported on some safeguarding forms that the resident had an assessed mental health disorder however this was not documented in their assessment of need. Additionally, there was no evidence that a wellbeing review and wellbeing care plan had been completed in light of the reported changes experienced by this resident over the past 12 months. The provider's statement of purpose set out that a wellbeing assessment and care plan was to be developed if staff noticed a resident struggling in any aspect of their lives. There was no such assessment or care plan available on this resident's file.

The statement of purpose for the designated centre stated that monthly resident

meetings were to take place to support residents to make decisions relating to the running of the designated centre. The inspector was informed that residents chose not to have these meetings and to have individual keyworker meetings instead. However, these meetings were not documented and so, it was unclear how residents were consulted with and participated in the organisation of their home.

It was apparent, in conversations with residents, staff and through a review of documentation available that the safeguarding and compatibility issues had a significant impact on residents' rights. One resident, in particular, spoke about how they regularly did not have free access to all parts of their home, how they had to leave their home on occasions and how they had been unable to have their partner or friends over for dinner. The resident also described feeling compelled to assist with activities of daily living such as dressing the other resident or making their bed. The resident stated that they did not wish to provide this assistance but that it was hard to say no as the other resident would become angry. The resident stated that they felt safer when staff are in the house, however, the other resident would not co-operate with increased staffing. It was clear that this resident did not have the freedom to exercise choice and control in their daily life. Furthermore, it was evident that both residents' privacy and dignity in relation to their personal and living space, their personal care and their relationships was not respected.

Regulation 25: Temporary absence, transition and discharge of residents

Transition planning had not been conducted in a manner that was planned, safe and in accordance with the residents' assessments of need. There was a lack of transparent criteria informing the move to alternative centres. It also was not clear if this move was a temporary transition in response to safeguarding concerns or was a more long-term discharge. It was not evidenced that residents and their representatives had been wholly consulted with and had agreed to the transition. The lack of transition planning had a significant impact to the wellbeing of residents with residents reporting that they were shocked. Residents were anxious and distressed when discussing the potential move with the inspector.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The residents' assessments of need had been recently reviewed, however, they did not comprehensively and consistently reflect the residents' assessed needs, in particular their mental health needs. There was an absence of care plans which outlined the supports required by residents as per their assessed needs. The registered provider had not ensured that arrangements were in place to meet the

needs of each resident.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had failed to protect residents from all forms of abuse. There were multiple documented incidents of peer-to-peer physical and psychological abuse with one resident being significantly impacted. Residents and staff had made the provider aware of these instances, however, the provider had not responded in a timely manner to ensure that all residents were protected.

Systems for recording and reporting incidents of abuse were inconsistent and it was not evidenced that all incidents were notified to the Chief Inspector or the safeguarding team in line with national policy. Safeguarding plans were ineffective as residents continued to be subjected to instances of abuse.

Under this regulation the provider was required to address an immediate risk that was identified on the day of inspection. The manner in which the provider responded to the risk did provide assurance that the risk was adequately addressed.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were not adequately consulted with in relation to decisions regarding their care and support. Residents informed the inspector that they did not have freedom to exercise control in their lives. One resident stated that they had informed staff that they were unhappy with their living arrangements several times but that nothing was being done about this. It was documented on several occasions that this resident was restricted from accessing all parts of their home or that they had to isolate in their bedroom or leave their home due to the behaviour of the other resident.

The residents' privacy and dignity in respect of their personal relationships was not respected with residents stating they were unable to receive visitors. Additionally, the privacy and dignity of each of the residents was impacted by one resident frequently being asked to assist the other residents with personal care and activities of daily living.

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 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for B Middle Third OSV-0003719

Inspection ID: MON-0036565

Date of inspection: 23/03/2022

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: • The Person in Charge reviewed the centers roster on the 24/3/2022 to reflect accurately staffing hours and staffing in the center including weekends - 3.8 WTE. • All staff hours allocated to the centre is clear on the roster. • The Registered Provider had approved enhanced staffing levels on the 25/3/2022 to include sleepover and all day weekends • The Person in Charge will publish a monthly staff roster for B Middle Third outlining the hours allocated to the designated centre and the staff on duty to meet the assessed needs of the residents. • The Registered Provider reviewed the centers roster again on the 5/4/2022 to reflect accurately staffing hours and staffing in the center to support resident .9 WTE.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge has updated the Statement of Purpose on the 24/3/2022 and 5/4/2022 to include staff WTE • Annual report was submitted to HIQA 26th March 2022. • Compatibility concerns identified in the annual report and redress efforts by the provider. • Residents were reviewed at SMH Residential Approvals Committee on 28/1/2022, 25/2/2022, 25/3/2022 and 6/4/2022. • Residents have weekly therapeutic interventions from Clinical Psychologists. • Residents were provided with mediation to agree ground rules for living together. • One resident moved to alternative accommodation 5/4/2022 • Director of Adult Service and Service manager met with resident and their representative on the 12/4/2022. • Resident has been supported to make application for housing to Dublin City Council and	

is currently on housing list.
• The PIC and Service Manager has revised all risk assessments and support plans to identify and maintain the safety of the residents. PBS Guidelines in place review date 21/07/2022.
• Separate MDT review (ICM) meetings took place 18/01/22, 24/03/22, 25/03/22 31/3/22, 7/4/2022, and another scheduled for the 25/4/2022 for both residents.
• Clinical Psychologist supported resident by devising a visual pathway for making complaints.
• AON were reviewed and updated for both residents
• The Person in Charge has reviewed the Safeguarding plans in the centre and liaised with SMH, Designated Officer.
• The Person in Charge will ensure data captured in the monthly data reports, quality enhancement plans, annual reviews and 6 monthly audits is used effectively to inform the centre's MDT in relation to supports required for the residents.
• The registered Provider submitted an urgent compliance plan to HIQA 29/03/22 that addressed the risk of abuse.
• A full review / audit of all notifications to HIQA and National safeguarding team have been completed.
• Director of Adult Services updated CHO IMR on compatibility issues 9/2/2022, 9/3/2022 & 13/4/2022

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Person in Charge has updated the Statement of Purpose on the 24/3/2022 and 5/4/2022 to include staff WTE
• Key workers have monthly meetings with the residents. These meetings are documented and held in residents files.The agenda for the meetings will support residents to be actively involved in the running of the designated centre and will reflect their wishes.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
• Current residential placement has been under review since December 2021
• The Person in Charge will arrange Individual Coordination Meetings as required to review the residents will and preference regarding future optional residential placements.
• The residents and their representatives will be consulted and included in all possible outcomes regarding alternative residential placements.
• On the 28/3/2022 representatives of the registered provider, Director of Adult Services met with residents to discuss will and preference and increased staffing levels. Reassurance was provided on the process.
• Review all options of living with each resident
• Regular Individuals Coordination Meetings take place to review resident needs.
• Resident moved to alterative accommodation on 5/4/2022 in line with SMH policy and will and preference.

• Director of Adult Services met with resident and representative on 12/4/2022 to discuss will & preference and options going forward.

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:
• The Person in Charge and residents' keyworkers have reviewed the Assessment of Need for each resident to reflect the will and preference in relation to future alternative living opportunities completed on 30/03/2022, further review completed on 15/04/2022.
• Residents have weekly therapeutic interventions from their allocated Clinical Psychologists.
• Resident moved to alternate location under consultation and agreement.
• One resident was supported to make application to local authority for housing July 2021
• Resident is confirmed to be on Dublin City Council housing list.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A Safeguarding audit has been completed in the centre by the Designated Officer and Safeguarding team. All information was submitted on 28/3/2022.
• The Registered Provider approved eenhanced staffing levels on 24/3/2022, including sleepover to support both residents safety and to respond to safeguarding concerns. This remained in place until a resident transitioned to another residential house on the 5/4/2022.
• Designated Officer met with both residents
• A review of Safeguarding plans for residents Was completed.
• Residents have weekly therapeutic interventions from Clinical Psychologists.
• Residents were provided with mediation to agree ground rules for living together.
• HSE Community Safeguarding team are aware of concerns and all PSF have been submitted.
• SMH Designated Officer had been in contact with HSE Safeguarding team 25.03.22. Met with team 8/4/2022.
• Residents were reviewed at SMH Residential Approvals Committee on 28/1/2022, 25/2/2022, 25/3/2022 and 6/4/2022.
• The Person in Charge and Safeguarding team will protect the residents from abuse by submitting all notifications to regulatory bodies as required in a timely manner.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Person in Charge has reviewed the current systems in place to support the rights of individual residents.
• Individual key worker meetings have been introduced to give residents the space and privacy required to meet the care, support and freedom they wish to pursue in their daily lives.
• Principal Social worker and Service Manager met with both residents to discuss will and

preference 24th March 2022.
• The Registered Provider approved enhanced staffing levels on 24/3/2022 including sleepover to support resident's safety and ensure the rights of service users are upheld.
• Director of Adult Services met with residents to discuss will and preference and increased staffing levels on the 28.3.22 and provided reassurance on the process.
• Resident has chosen and supported to move to alternative accommodation on the 05/04/2022
• The visitor's policy for the centre has been reviewed. Residents can receive visitors at their convenience and will be informed when Covid 19 restrictions impact on a visit. Staff will support residents with alternative options when necessary.

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	05/04/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Red	24/03/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery	Not Compliant	Red	05/04/2022

	of care and support in accordance with the statement of purpose.			
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	Red	05/04/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	05/04/2022
Regulation 25(4)(a)	The person in charge shall ensure that the discharge of a resident from the	Not Compliant	Red	05/04/2022

	designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.			
Regulation 25(4)(b)	The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner.	Not Compliant	Red	05/04/2022
Regulation 25(4)(c)	The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed in accordance with Regulation 5(1) and the resident's personal plans.	Not Compliant	Red	05/04/2022
Regulation 25(4)(d)	The person in charge shall ensure that the discharge of a resident from the designated centre is discussed, planned for and agreed with the resident and, where appropriate, with the resident's representative.	Not Compliant	Red	12/04/2022
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not	Not Compliant	Red	05/04/2022

	less than one year.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Red	05/04/2022
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Red	05/04/2022
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 needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	05/04/2022
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,	Substantially Compliant	Yellow	30/03/2022

	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.			
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	Red	15/04/2022
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.	Not Compliant	Red	15/04/2022
Regulation 08(2)	The registered provider shall	Not Compliant	Red	23/03/2022

	protect residents from all forms of abuse.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Red	08/04/2022
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	Red	05/04/2022
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	Red	05/04/2022
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in	Not Compliant	Red	05/04/2022

	accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Red	05/04/2022