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:	SVC - SDN
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 7
Type of inspection:	Short Notice Announced
Date of inspection:	15 June 2021
Centre ID:	OSV-0004023
Fieldwork ID:	MON-0033258

About the designated centre

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

SVC - SDN is a designated centre located on a campus setting in North Dublin which provides residential care and supports for up to 11 residents with complex needs, mental health diagnoses and behaviours of concern. The centre is comprised of five separate spaces which include a range of apartment spaces, bedrooms, living rooms, bathrooms, kitchen areas and enclosed garden spaces. There are additional staff areas which include an office space, storage rooms, visiting room and staff bathrooms. The staff team employed in the centre are made up of a person in charge, a clinical nurse manager, social care workers, staff nurses, care staff and household staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Tuesday 15 June 2021	09:00hrs to 16:35hrs	Thomas Hogan	Lead
Tuesday 15 June 2021	09:00hrs to 16:35hrs	Marie Byrne	Support

What residents told us and what inspectors observed

From meeting with residents and from what the inspectors observed, there were high levels of non-compliance with the regulations inspected against during this inspection. Overall, the registered provider was found to have failed to ensure that services being provided in the centre were appropriately monitored and to ensure that there were effective governance and management arrangements in place. In addition, the inspectors found that residents were living in a highly restrictive environment and the registered provider had not ensured that appropriate supports were provided to ensure there was meaningful consideration of the impact of these restrictive practices on their human rights. The inspectors found that in the case of some residents, the registered provider was not meeting their support needs and acknowledged this during a meeting held with the inspectors at the commencement of this inspection.

This inspection was completed as part of the regulatory plan for this centre following a recent inspection which was carried out in December 2020. At that time, poor findings were identified which resulted in a meeting with the registered provider where a caution was formally issued. In response, the registered provider submitted a service improvement plan to the Office of the Chief Inspector which set out a number of actions including the establishment of a local governance oversight committee and the commitment to address the culture present in the centre. However, at the time of this inspection the inspectors found that residents were continuing to experience a poor quality of life. Despite a number of actions outlined in the service improvement plan having been implemented by the registered provider, minimal positive improvements had been brought about in the lived experience of residents in the centre.

The inspectors met with six residents who were living in this centre at the time of the inspection. The resident group presented with complex disabilities and in some cases required significant supports to manage behaviours of concern. Many of the residents were unable to verbally communicate with the inspectors, however, some said "hello" and were pleased to welcome the inspectors into their homes. Most of the residents met with were in receipt of high levels of staffing supports with one-to-one or two-to-one ratios in place. Some residents were making jigsaws while others were going out on centre transport for a walk in the community.

While the findings of the inspection were poor, the inspectors did identify some positive developments. These included the transfer of one resident to another designated centre in the time since the last inspection. This was described as positive transition which resulted in improved quality of life for a number of individuals. In addition, the inspectors found that in some areas of the centre colourful garden furniture had been installed along with a trampoline and football net. In one apartment, the inspectors observed a resident and a staff member baking cupcakes. All observed interactions between the staff team and the resident group were found to be respectful and carried out in a kind manner. The registered

provider also outlined to the inspectors that they were in the process of recruiting a full-time occupational therapist to work in the centre along with increasing the resources of allied health professionals.

The inspectors completed a full walk through of the centre in the company of the person in charge and person participating in management. The premises of the centre, in some areas, was found not to be fit for the provision of residential services. The centre was found not to be designed or laid out to meet the needs of residents. In some areas there was poor ventilation and strong malodours as a result of the poor circulation of air. These areas included living rooms, bedrooms and bathrooms. In some areas of the centre it was uncomfortably warm and it was observed that due to the presence of window restrictors and acrylic sheet coverings on widows, residents could not regulate the temperature of some rooms during summer periods. The inspectors also found that the centre was not clean in a number of areas and issued an immediate action for the completion of a deep clean of the centre within 24 hours of the inspection. In the time since the last inspection, the registered provider had arranged for the painting of the centre throughout and for the refurbishment of a number of bathrooms, however, despite this the centre remained institutionalised in nature and basic requirements were not in place. For example, in a number of bathrooms and toilets there was no toilet paper, hand soap or hand towels available to residents.

There was clear evidence to demonstrate that the human rights of the resident group had not been appropriately considered or respected. There was widespread use of restrictive practices in the centre and the inspectors found that in some cases these appeared to be excessive and unjustified. For example, in the garden space of one apartment there was a steel casing enclosing the gable end of the building which the inspectors were told was to prevent the destruction of property. However, in the same area there was a recent addition of a light weight garden shed which was acting as a donning and doffing space for staff to change into and out of personal protective equipment. This garden shed had no encasing and was not the subject of property destruction attempts. In other cases, there was closed-circuit television (CCTV) actively in use in two apartments in the centre. The inspectors were informed that this was only ever used during times of behavioural escalation, however, when documentation was reviewed it was also found to be used on occasions prior to staff entering these apartments to check the location of the residents. There were some restrictive practices in place which had not been identified as such by the registered provider and there was evidence to demonstrate that the organisation's policy on the use restrictive practices (dated December 2018) was not being implemented in practice. For example, some residents did not have access to running water in their apartments and there was an absence of evidence to demonstrate that all less restrictive alternatives had been considered where such alternatives existed. In addition, the requirements of the organisation's restrictive practice policy that "a person-centred approach is essential" and "opportunities to identify reduction in the frequency or level of restriction must be built in to the individual's care plan or equivalent" were found not to be taking place in practice in this centre.

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

The inspectors found that this centre was not appropriately managed and there was limited oversight of the care and support being delivered to residents. The findings of the inspection were poor and reflected a centre where there was a need for significant improvement in the standard of services being provided. The centre was operated in an institutionalised manner and did not embrace person-centred or human rights based models of care and support.

There was an absence of appropriate leadership in place in the centre and the governance and management arrangements which were in place were not effective. Of the seven regulations inspected against as part of this inspection six were found to be not compliant. An immediate action was issued to the provider instructing them to carry out a deep clean of the centre within 24 hours of the inspection.

While the registered provider had established a local governance oversight committee in response to the findings of the December 2020 inspection, the inspectors found that overall, there had been minimal improvement in the lived experience of some residents as a result. In fact, there was evidence to demonstrate that recommendations in place from an ethics committee review of the use of some restrictive practices relating to the need for the completion of data impact assessment had not been completed by the registered provider at the time of the inspection despite the recommendation being made in March 2021.

The provider had engaged with the regulator in relation to a plan to upgrade part of the centre which culminated in a request for a meeting with the inspectors. This meeting was facilitated with representatives of the registered provider on the morning of the inspection who outlined a long term plan for one resident along with the significant challenges they experienced in the development of that plan. At that time the provider used the opportunity to inform the inspectors how they had self-identified some of the issues identified during the course of this inspection.

While the outlined plan was welcomed by the inspectors, the time line for the implementation of the plan along with the absence of a formulated plan for the remaining nine residents were grounds for additional concern. In addition, the inspectors acknowledged the impacts of the COVID-19 pandemic on the implementation of the registered provider's responses and outlined actions submitted in response to the previous inspection of the centre completed in December 2020.

Regulation 16: Training and staff development

The staff team had completed training and refresher training in line with the organisations policy. In addition, staff members had completed a number of additional training programmes in line with residents' needs. For example, a number of staff members had completed infection prevention and control training and training in relation to residents' rights. Staff were in receipt of regular formal supervision to support them to carry out their roles and responsibilities to the best of their ability.

Judgment: Compliant

Regulation 23: Governance and management

There was an absence of effective management systems in the centre along with an absence of effective leadership. As a result, there was limited oversight of the care and support being delivered to residents and there were ongoing high levels of non-compliance with the regulations. While the registered provider had made some improvements in self-identifying areas that required improvements, overall, the inspectors found that there had been little improvement in the lived experience of residents as a result of these actions. In addition, the inspectors found that a recently completed provider visit to the centre did not recognise many of the concerns and non-compliances identified by the inspectors during the course of the inspection.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that the services provided through this centre did not promote a good quality of life for some of the residents availing of its services. There was clear evidence to demonstrate that residents were not supported to exercise their personal rights where possible.

The inspectors found that the designated centre was not clean in some areas and overall, was not designed or laid out to meet the needs of the residents who were availing of its services. In many areas, the inspectors found that there was limited space for residents to live, move about and enjoy outdoor areas. The standard of the premises was found to be poor and did not provide for a homely or comfortable environment to live.

Due to the significant use of invasive restrictive practices, the limited freedom of movement for residents, the collective approach to the provision of behavioural supports, the limited oversight of the use of restrictive practices, the poor living environment, and the absence of meaningful supports for promotion and consideration of the rights of the resident group, the Office of the Chief Inspector referred the concern to the Health Service Executive's National Safeguarding Office as these practices could be considered as institutional abuse.

Services provided in the centre were not delivered through person-centred or human rights based approaches and instead the centre's culture facilitated an institutionalised model of care. For example, at the time of the last inspection of the centre in December 2020 the inspector observed CCTV cameras in the bedrooms of two residents. In one case, the inspector was informed that these were not active and were never used. When the inspector asked why they remained in place the registered provider responded by stating that they may be required at a later date. At the time of this inspection the CCTV cameras remained in place in this resident's bedroom and when the inspectors again asked about them a senior manager arranged for their immediate removal. This, the inspectors found, was an example of an institutionalised practice which created a standardised restrictive approach instead of individually meeting the needs of residents through bespoke responses and person-centred approaches.

The inspectors found that the registered provider was not meeting the needs of some residents living in this centre. Compounding this finding was the absence of comprehensive assessments of need to clearly identify the needs of the resident group. Where there were assessments, there was considerable ambiguity of what the actual needs of the residents were. In some cases, there was an absence of support plans to address the needs of residents which had been identified. The inspectors also found that there were support plans in place despite assessments highlighting that there were no needs in that specific area. This lack of clarity on the assessed needs of residents, the inspectors found, was contributing towards the shortfalls in individuals receiving the supports they required.

A review of the manner in which residents were supported with their behaviours of concern found that there remained an absence of appropriate guidance to inform staff on how to respond to behaviours as they occurred in a proportionate manner. For example, guidance in place for some residents who displayed a range of behaviours, including "shouting" or "not accepting a response from staff", was to withdraw from the area, lock a door and garden gate, activate CCTV cameras, commence two minute observations and to contact a senior manager. The inspectors noted that there was an absence of guidance for early signs of behaviours of concern to support de-escalation and prevent crisis behaviours occurring. The inspectors found that it was difficult to locate information on how to support residents as a result of the format of plans which were in place. It was not evident from a review of the plans which were in place that the least restrictive intervention was being promoted for the shortest duration necessary. In addition, the provision of behavioural supports was not individualised or person-centred as required by the organisation's policy on supporting persons with behaviours of concern (dated April 2021). Instead, the inspectors found, there was an

institutionalised approach to the provision of behaviorual supports which did not reflect a human-rights based model.

Regulation 17: Premises

The design and layout of some areas of the centre were found not to be meeting residents' individual or collective needs. The provider was aware of this and shared their plans to bring about the required improvements with the inspectors at the start of the inspection. In some cases, adequate private and communal accommodation including adequate social, recreational, dining and private accommodation was not available for residents. The amount of space available both internally and externally was limited for some residents. The inspectors found that the premises of the centre were a contributing factor to the use of invasive restrictive practices such as the use of CCTV.

In some cases, the inspector found that the premises of the centre were not fit for the provision of residential services. In other areas, in line with the findings of previous inspections, the inspectors found that significant improvements were required in relation to the maintenance and upkeep of the premises. These areas for improvement were found to be negatively impacting on the comfort and homeliness of residents' homes. In addition, there were a number of areas in the centre which were not found to be clean during the inspection. Examples of areas for maintenance or repair included, damaged and marked floors in a number of areas, a number of bathrooms required refurbishment, there were marks on a number of walls, there was chipped paint in a number of areas, and there there was damage to vanity units in two bathrooms. Improvements were also required in relation to ventilation in a number of areas in the centre.

The inspectors acknowledge that some areas of the centre were found to be clean and well maintained. Improvements had been made since the last inspection in some areas including the refurbishment of a number of bathrooms, works to a number of gardens and painting of a number of areas.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed a sample of residents' assessments and personal plans. From the sample reviewed, it was not evident that comprehensive assessments of need were completed for residents and as a result there was considerable ambiguity as to what the actual needs of residents were. Where there were assessments completed it was also not clear what needs had been identified. In some cases, needs were identified and there were no corresponding support plans in place. In

other cases there were support plans in place where assessments stated that that residents had no support needs. A review of support plans found that these were not reviewed on at least an annual basis by a multi-disciplinary team and the effectiveness of the plans had not been considered.

The registered provider acknowledged that they were not meeting the needs of some residents who were availing of the services of this centre. The inspectors found that in the cases of some residents where specialised multi-disciplinary professionals assessments and reports had been completed (dated 2017 and 2018), that some recommendations arising form these reports were not implemented 2021.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Despite the complex presentation of residents, there remained an absence of clear behaviour support guidance for staff. Where there was guidance, the inspectors found in some cases that this did not reflect the promotion of the least restrictive alternative interventions for the shortest duration necessary. While there was some improvement in cataloguing the guidance documents that were in place, the inspectors found that accessing and locating behavioural support plans to be difficult. The justification for the use of some restrictive practices was not clear to ensure they were proportionate to the needs of residents. In addition, there were restrictive practices in use which had not been identified as such by the registered provider. This included high levels of security measures such as high walls and metal fencing surrounding a small garden which were not reviewed as a restrictive measure. The oversight of the use of restrictive practices was limited and required improvement. The least restrictive measures were not used for the shortest duration possible.

Judgment: Not compliant

Regulation 8: Protection

Overall, the inspectors found that there was an institutionalised approach to the provision of care and support in the centre. Some practices, including the high levels of use of restrictions to manage behaviours of concern, were found by the inspectors to meet the definition of institutional abuse. Some examples include the collective approach to the provision of services to residents, the limited oversight of the use of restrictive practices in the centre which was disproportionate to levels of restrictions in use, the poor living environment which was provided for in the centre, and the absence of meaningful supports for promotion and consideration of the rights of the resident group. In response to these concerns, the Office of the Chief

Inspector completed a referral to the Health Service Executive's National Safeguarding Office.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspectors found that the centre was not operated in a manner which respected the disabilities of some residents. While the provider had committed to addressing the culture present in the centre, at the time of the inspection the inspectors found that culture of the centre did not promote or protect the rights of the resident group and there was an absence of evidence to demonstrate that residents participated in and consented to decisions about their care and support. In some cases, residents lived in highly restrictive environments and had limited freedom of movement. This negatively impacted the civil liberties of some residents who had limited choice and control over their daily lives. The physical environment in which some residents were living was found by the inspectors not to be fit for the provision of residential services.

There remained an absence of referral of residents to independent advocacy services despite the significantly restrictive living environment in which they lived. The provider had not completed any referrals for advocacy supports in the time since the last inspection and one set of minutes of a meeting of the governance oversight committee stated that independent advocacy services did not "...have the specific expertise around restrictive practices".

Overall, the condition of the centre and the institutionalised approach to the provision of services did not respect the dignity of some residents who were availing of the services of this centre.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for SVC - SDN OSV-0004023

Inspection ID: MON-0033258

Date of inspection: 15/06/2021

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Following verbal feedback on the day of inspection, immediate action was taken to strengthen the governance and management within the designated centre. There is now an enhanced support structure in place within the designated centre. The Service Manager is allocating dedicated hours weekly to the centre to provide leadership and direction to the team. A named CNM3 has been allocated to provide dedicated direct support to the centre for 19.5 hours per week. The purpose of this role is to work with the local team on the ground to identify areas for improvement, reflect on and positively challenge support approaches. There are also twice daily visits to the centre by person providing senior cover to provide support and monitor that practices in use reflect a person centred approach and is safe and appropriate to residents needs. The PIC has changed her roster to work across a 5 day working week to provide greater oversight and management. In addition the service manager has conducted a review of resources in order to facilitate the recruitment of a role which will enhance the governance and oversight of the centre. This will be progressed by the HR Department. Weekly quality and safety visits by the Service Manager and a member of the executive team will take place to monitor and provide support so that the service provided is safe and appropriate to residents needs and seeks to uphold the rights of each individual. Quality and safety visits took place on 21/06/21, 02/07/21 and 09/07/21. Feedback from all quality walk arounds will be documented, discussed and provided to PIC/PPIM with agreed actions, timeframes and person responsible clearly identified. The schedule for unannounced provider visits has been increased and will be carried out at intervals of 3 months for a 9 month period to ensure appropriate oversight of the governance and management of the centre. The first of these unannounced visits has been completed on the 09/07/21 and the recommendations included in the quality enhancement plan which is actioned by the PIC and PPIM.	

The Registered Provider has closed this centre to admissions and is working towards reducing capacity. An application to vary from 11 places to 10 places will be submitted by 30th July. A key driver for this is the Registered Provider's decongregation strategy with prioritisation for residents living in this designated centre based on the outcome of their Individual Preference and Need Assessments (IPNA).

The Register Provider's governance and oversight group chaired by the ACEO consisting of members of the Senior Management team, members of the designated centre and MDT remains in place. This governance oversight group is responsible for ensuring that all actions identified in the HIQA report are executed in line with agreed time frames. This group has revised the terms of reference: to include the monitoring of the effectiveness of the enhanced support structure to ensure that the new oversight system is resulting in positive changes for the residents.
The oversight group will meet weekly to monitor ongoing progress with the action plan.

The Registered Provider has ensured that individuals meetings were held with all families of residents living in the designated centre to inform them of the inspection findings, to share with them the action plan and to listen to any comments or concerns they raise.

The registered provider has committed to providing an education and training programme for staff team to include Its My Life Training and the Good Lives Learning Series over the next 12-24 months as part of its ongoing commitment to continuous improvement, and practice and system changes to meet the real needs of individuals. This will be supported by a tandem roll out of a leadership programme for senior managers, on innovation and change exploration at a strategic level.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A comprehensive review of all required maintenance issues has taken place and a planed programme agreed to address same. This included review of flooring, bathrooms, ventilation and windows to ensure that temperature can be regulated.
Four bathrooms will be upgraded to a high specification.
An adapted kitchen will be installed in a communal area that can be accessed by all residents.
Windows with toughened glass and opening for purge ventilation will be installed in one part of the designated centre.
Cooling units have been procured and are in place for trial in two areas within the centre as an interim measure while the provider progresses plans to install high specification ventilation system which is already in place in one part of the centre.
In the main bathrooms the six fans will be serviced (and replaced where they were found not to be operating to specified duty) as per building Regulations. This is programmed to be complete by 30/07/21 and will have a PIR activated switch which will automatically switch on the fans once a person enters the room (day or night).

Flooring will be replaced in identified areas of the centre. This is scheduled to be carried out on a phased basis commencing on site on 23rd August with projected completion date 17th September 2021.

One additional WTE post of dedicated household hours have been allocated to the centre with effect from 21/06/21. A cleaning audit has been carried out in the centre. An external cleaning company will be contracted to provide additional enhanced cleaning in the areas and for the frequency identified in the audit.
A comprehensive environmental deep clean of the centre took place on 16.06.21.
A monthly hygiene audit will be carried out by the CNM2 in Infection Prevention and Control. The first audit was completed on 01/07/21 with an action plan to be progressed within the overall governance process.

The centre was fully painted recently but requires ongoing painting. A painter has being assigned specific weekly hours to the centre with immediate effect to ensure premises are painted and maintained in good condition.

An engagement process has been undertaken with each person to enhance and upgrade their home in line with their expressed will and preference. This process has informed a plan to redecorate the designated centre in accordance with each person's needs and preferences.

Alternative living accommodation is being explored for one individual with high complex needs – a referral has been made to external providers via HSE who are awaiting feedback in relation to referrals. If transfer to an alternative service is not possible the Registered Provider is also exploring the possibility of creating capacity in another designated centre which will provide the opportunity for this individual to transfer to a suitable environment with the appropriate supports.

The Registered Provider will progress an application to vary from 11 residents to 10. This will provide for additional space to be utilised by other individuals living in the centre to to increase the private and communal space available in the centre for persons remaining.

Each individual is being supported to have a comprehensive individuals needs and preference assessment (IPNA) carried out to determine their needs and preference in relation to their living environment. The individuals' needs and preferences will inform future planning of premises and the right environment to ensure it meets the needs of each resident. 6 IPNAs have being completed and 4 more will be completed by mid September.

As each person's IPNA is completed and the type of living accommodation and supports they require is identified a referral will be made to the Admissions, Transfer and Discharge committee.

3 individuals have being identified for transfer to a community house as part of a decongregation plan. The Registered Provider is working closely with the HSE to secure the necessary funding.

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:
Each resident is being supported to have a comprehensive individuals needs and preference assessment (IPNA) carried out to determine their needs and preference in relation to their living environment and supports for the person to support them on a pathway to lead their best lives. The individual's needs and preferences will inform future planning of premises to ensure it meets the needs of all residents. 6 IPNAs have been completed and four more are scheduled in the next 8 weeks. As IPNAs are finalised a full MDT meeting including the person and/or their representatives will take place to support the development of an action plan for each person based on the findings which will be incorporated into their personal plan and will have a clear focus on upholding their human rights and their expressed will and preference regarding supports.
Each persons' personal plan has been audited to ensure that all areas of need have been identified and that corresponding support plans are in place. This includes all recommendations from MDT input from the completed IPNAs and any other MDT recommendations. MDT members have been asked to review previous reports to ensure any outstanding recommendation that require action are included in the IPNA. The personal plan template is under review to ensure it accurately reflects the identified needs and outlines the unique supports of residents with complex behaviour needs in the centre.

Each persons intimate care guidelines have been reviewed to outline how toiletries and bathroom supplies are provided and a risk assessment completed where specific supports are required.

A Senior Occupational Therapist post is currently being recruited to support individuals living in the designated centre. This post will have dedicated hours working directly with frontline staff in order to assess and recommend appropriate occupational therapy programs, environmental adaptations, activities, skill development and adaptive aids taking into account person centred needs. The Occupational Therapist will actively monitor and oversee all therapeutic interventions and supports they implement.

There will be an annual MDT for each person in the designated centre and any recommendations or changes identified will be incorporated into the personal plan. The scheduled date has being circulated to relevant MDT members by the PIC.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Each persons care plan will be reviewed to provide a distinct positive behaviour support plan to ensure ease of access to information for staff to guide them on supporting responsive behaviour including proactive and reactive strategies to be used in responding to each person's behaviour needs. Two Clinical Nurse Specialists in Positive Behaviour Support have been allocated to the designated centre.
All restrictive practices have been reviewed in line with the Registered Providers policy and a restriction reduction plan is being agreed for each person where appropriate reduction/removal of restrictions are within the context of the findings of the IPNA. Following completion of IPNAs a number of restrictions have being removed. This has occurred as a result of reflection on the information from the IPNAs and previous and current HIQA reports by the Registered Provider with a shift in practice from a risk averse approach to one that focuses on human rights and considers risk versus benefits. An external professional with expertise in human rights has being engaged by the Registered Provider to further review a number of restrictive practices under the United Nations Convention on Rights of Persons with Disabilities
and to ensure that any restrictions in use are justified and proportionate to the needs of residents and implemented for the shortest duration possible. An advocate has commenced engagement with one individual with complex high support needs and is attending a restrictive practice review meeting on the 19/07/21 to ensure that the person's human rights are upheld.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The safeguarding procedures of the Registered Provider have been followed and the Head of Social Work has linked with the HSE safeguarding team. An initial engagement meeting took place with the Head of the CHO9 safeguarding team in the HSE to provide background information and outline the interim safeguarding plan. Notifications have been made to HIQA in line with regulatory requirements on 28/06/21.

An external professional with expertise in human rights has being engaged by the Registered Provider to review practices within the centre and make immediate, interim and long term recommendation for progressing the designated centre towards a human rights based service which is safe for and respectful of the will and preferences of residents.

All staff in the centre have completed safeguarding training. The Social Work team are providing additional safeguarding education sessions for the staff team.

A specialised programme of training with a focus on changing culture and seeking to create the vision of each persons life through their PCP has been developed and will commence with identified keyworkers. This will be linked to a plan for decongregation as outlined in the Registered Provider's strategic plan.

The Registered Provider has closed this centre to admissions and is working towards reducing capacity. This will improve the living environment in the centre. An application to vary from 11 places to 10 places will be submitted by 30th July.

Representatives from the HSE have visited the centre with the CEO and provider representative since the inspection and continue to engage with them to progress required work.

The Registered Provider has ensured that individuals meetings were held with all families of residents living in the designated centre to inform them of the inspection findings, to share with them the action plan, seek their input and to listen to any comments or concerns they raise.

The Registered Provider has a governance oversight group in place to seek and obtain assurances that standards and practices in the centre are in line with individuals rights. The frequency of meetings will be increased to weekly to monitor progress of action plan and the positive impact on the lived experience of each person.

Review of all care plans has commenced to ensure a person centred and human rights based approach to all aspects of individual care.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A referral has being made to the National Advocacy Service for each individual living in the centre. An advocate has commenced engagement with one individual with complex high support needs and is attending a restrictive practice review meeting on the 19/07/21 to ensure that the person's human rights are upheld.

All restrictive practices have been reviewed in line with the Registered Providers policy and a restriction reduction plan is being agreed for each person where appropriate reduction/removal of restrictions are within the context of the findings of the IPNA. Following completion of IPNAs a number of restrictions have being removed. This has occurred as a result of reflection on the information from the IPNAs and previous and current HIQA reports by the Registered Provider with a shift in practice from a risk averse approach to one that focuses on human rights and considers risk versus benefits. An external professional with expertise in human rights has being engaged by the Registered Provider to review restrictive practices and to provide education to staff on rights awareness to ensure residents exercise civil, political and legal rights.

The Registered Provider has ensured that the individuals are supported to exercise choice and control over their daily lives by putting a process in place to review and update their personal plans with their needs, wishes and preferences clearly documented.
A rights assessment tool will be completed for each individual in order to identify any impact of restrictive interventions on basic human rights.
Each resident is being supported to have a comprehensive individual preference and needs assessment (IPNA) carried out to determine their needs and preference in relation to their living environment. The residents' needs and preferences will inform future planning of supports required by each person to ensure it meets the needs of each individual. 6 IPNAs have being completed and four more are scheduled to be completed by 30th August 2021. As IPNAs are finalised a full MDT meeting including the person and/or their representatives will take place to support the development of an action plan for each person based on the findings which will be incorporated into the personal plan.
Each residents personal plan is being reviewed and will reflect how each person participated in and consented with supports where necessary to the decisions about their care and support. (easy read version provided). This process is being progressed for each person living in the centre.
The Registered Provider has closed this centre to admissions and is working towards reducing capacity. This will enhance the privacy and dignity for all residents and provide increased living space.
The PIC is facilitating residents meetings fortnightly with a clear focus on supporting individuals to exercise choice and autonomy over their daily lives. The meetings will be 1:1 or for a number of residents who require individualised supports.
A programme of learning in developing cultures of person centeredness will be facilitated for staff which will enable them to support the service delivered support plans that evidence each person has maximum control and choice in their daily lives in line with their identified needs and preferences.
A data protection impact assessment has been completed in relation to use of CCTV in the centre.

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Red	11/10/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	11/10/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Red	28/06/2021
Regulation 17(7)	The registered provider shall	Not Compliant	Red	11/10/2021

	make provision for the matters set out in Schedule 6.			
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	09/08/2021
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.	Not Compliant	Red	09/08/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional,	Not Compliant	Red	23/08/2021

	of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
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	11/10/2021
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	11/10/2021
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/10/2021

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	30/10/2021
Regulation 05(4)(c)	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 is developed through a person centred approach with 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	Red	20/09/2021
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 needs or	Not Compliant	Orange	30/11/2021

	circumstances, which review shall be multidisciplinary.			
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	20/09/2021
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.	Not Compliant	Red	20/09/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/10/2021

Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Red	20/09/2021
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.	Not Compliant	Red	20/09/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Red	20/09/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates	Not Compliant	Red	20/09/2021

	intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	26/07/2021
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Red	20/09/2021
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	20/09/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes,	Not Compliant	Red	20/09/2021

	age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Not Compliant	Red	20/09/2021
Regulation 09(2)(d)	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 access to advocacy services and information about his or her rights.	Not Compliant	Red	19/07/2021
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	Not Compliant	Red	20/09/2021

	personal information.			