Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Mixed).

Issued by the Chief Inspector

Name of designated centre:	Liskennett Centre
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	04 April 2023
Centre ID:	OSV-0004263
Fieldwork ID:	MON-0030892

About the designated centre

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

The centre is a congregated setting and provides a home to 14 residents. It is based in a community setting in county Limerick. The campus is based around an equestrian centre. All of the residents have high support needs and are supported individually by a high staff complement, mostly on a one-to-one basis. The designated centre is purpose built and comprises of 14 individual apartments, divided into three sections. Each resident's apartment has its own front door and all the apartments have been finished to a very high standard, with a kitchen, living,dining area, bedroom and shower facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Tuesday 4 April 2023	09:00hrs to 18:00hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

The inspector observed that residents living in this centre enjoyed a good quality service that was tailored to their individual needs and preferences. At the time of this inspection, local management systems had been put in place to ensure a safe and person centred service was being provided. However, staffing levels in the centre were at times impacting on the oversight of documentation in the centre and some ongoing non compliance with the regulations was observed since previous inspections.

The centre comprised three separate units located around a central courtyard. The main building contained eight individual single occupancy apartments and a bedroom used by one respite resident only as well as a number of communal areas, laundry facilities and administration areas. The second unit had four ground floor single occupancy apartments and the third unit was a two storey farmhouse that had been converted into two single occupancy apartments. Although there were fifteen bedrooms in total in the centre, only fourteen were ever occupied at the same time. One respite resident preferred to stay in the main centre for respite breaks and this was facilitated by an additional bedroom for that resident in the main centre. Other respite residents used an apartment located across the courtyard from the main building. All apartments could be independently accessed from the outside by the residents and the apartments in the main building could also be accessed from a central corridor that looked onto an internal courtyard. There were interlinking doors between the four apartments in the second unit but the inspector was told that these were not used and were for emergency access only.

The residential buildings that made up the designated centre were located next to day service buildings and specialised equine facilities that were accessible to residents also. The centre was located on farmlands in a rural area and residents had access to numerous green spaces and ample open areas. Residents had the use of outdoor facilities, such as a swing, adapted bicycle, trampoline and seating areas. Some residents enjoyed gardening and were supported to decorate their individual patio areas to suit their individual preferences and tastes.

On arrival the inspector was greeting by the incoming person in charge and provided with a space to complete a review of documentation. The centre was spacious and laid out in a manner that respected the privacy and dignity of residents, with keypad access to each apartment. Each resident lived in their own apartment with a bedroom, kitchen/living area and bathroom. Residents had access to their own cooking and laundry facilities and there were also communal cooking and laundry facilities on site if required. Apartments were decorated in line with the individual preferences of residents and were bright and airy with ample natural light. A number of apartments had large murals painted on the walls that were custom designed for the residents and showcased their interests and talents. For example, one resident had a mural that included a farm scene that was reflective of their childhood memories, another had a mural reflecting their sporting interests.

Residents had storage facilities for their clothing and belongings. Overall, the centre was seen to be well maintained and nicely decorated throughout and was appropriate to meet the assessed needs of the residents that lived there. Sensory tiles and activity boards were observed in the communal sitting room area of the main building and there was a piano in the hall of the centre, with plans to move this to an area where it might be used more for the enjoyment of residents.

The inspector completed a walk-around of the centre with the person in charge and had an opportunity to meet with some of the residents in their apartments. One resident came to the room where the inspector was viewing documentation on a number of occasions during the day and interacted with the inspector briefly on these occasions. Some residents chose not to interact with the inspector and this wish was respected. Other residents were away from the centre attending day services, planned activities, and meeting with family members. The inspector had an opportunity to sit and speak with one resident in their apartment. This resident was supported by a staff member and was seen to be content in their surroundings. They chatted with the inspector about the activities they liked such as music and horse riding and told the inspector that they liked their apartment. They spoke fondly about the staff that worked with them regularly and were observed to have a good rapport with the staff supporting them and the person in charge. From the interactions viewed on the day of the inspection, it was seen that staff working in the centre were familiar with the residents they worked with and were knowledgeable about their support needs.

Questionnaires had been provided to residents and their representatives prior to this announced inspection and family members had been informed that the inspection was being carried out. Family members did not chose to speak with the inspector but a number of completed questionnaires were returned to the authority. The inspector saw that these provided positive feedback on residents' experiences of the centre. For example, one of the responses from a family member called the centre "a wonderful place" and indicated that their relative received a person centred service in the centre. The annual review also included feedback from residents and their representatives and this was overall positive. A satisfaction survey that had been completed in May 2022 by a family member indicated that there was some dissatisfaction in relation to communication with families.

Overall, this inspection found that there was evidence of good compliance with the regulations in this centre concerning the frontline care and support of residents and this meant that the residents living there were being afforded a safe and person centred service that met their assessed needs. However, some non-compliance remained in relation to personal plans, staff training and development and the notification of incidents in the centre and there was evidence that there had been gaps in the oversight of certain documentation in the centre during specific periods, such as when the local management team was changing. 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

Management systems in place in this centre were seen to provide for a good quality, responsive and person centred service to the residents living there. Local management systems had recently been put in place at the time of this inspection to ensure that the services provided within the centre were safe, consistent and appropriate to residents' needs. However, some ongoing non-compliance was found in relation to the notification of incidents, training and staff development and personal plans, reflecting some gaps in oversight at provider level.

This was an announced inspection carried out to inform the decision to renew the registration of the centre. The provider had submitted an application to renew the registration of the centre. Some of the information provided on this application was incorrect and some updated information was requested on the day of the inspection and in the period following the inspection..

A number of management changes had taken place in the months prior to this inspection. A new person in charge had recently been appointed to this centre and this individual was present on the day of the inspection. An area manager, who had also recently put forward as a person participating in the management of the centre was also present. Both individuals were familiar with the centre and were returning in new roles following a period of absence from the centre. The role of the person in charge was not full time at the time of the inspection and the provider committed to appointing a second individual as person in charge to ensure that oversight was maintained on a full time basis.

Throughout the day, a number of other members of management made themselves available to meet the inspector, including the chief executive officer and the quality and risk manager. The post of the quality and risk manager was a new role put in place by the provider and it was anticipated that this would provide an additional layer of support and oversight to the management of the centres run by this provider. The incoming person in charge was aware of their regulatory responsibilities and was committed to providing a person centred and good quality service in the centre. It was proposed that the incoming person in charge would have remit over two designated centres. The inspector spoke with the incoming person in charge about the plans they had in place to maintain oversight of this centre and the systems that were in place to place to support them in this. There were audit systems in place and the quality and risk manager outlined to the inspector plans to streamline and further improve the oversight systems this provider in place.

Residents were supported by a large staff team in the centre. Some residents were supported on a 1:1 basis in their apartments, while some residents in the main house shared a team of staff that supported them as required. Staffing had been an issue at the time of the most recent provider unannounced six monthly audit of the centre and had been escalated through the management chain as far as the CEO. Interim arrangements were put in place to manage this and staffing levels had

improved. However, at the time of this inspection, there remained some vacancies in the centre, including two vacant clinical nurse manager 1 (CNM1) roles. The person in charge acknowledged that this was impacting on the oversight of some documentation in the centre. However, the inspector saw that, where staff shortages did occur, the frontline care and support provided to residents was prioritised and the evidence at the time of this inspection indicated that efforts were made to minimise the impact of staff shortages on residents' lived experiences in the centre. For example, if possible familiar relief and agency staff covered staff vacancies. If this was not possible, unfamiliar staff worked alongside regular staff and where possible 1:1 supports were provided by regular staff that were familiar with these residents. This was important to ensure consistency of care for residents and to ensure that staff working with residents were familiar with their assessed needs and support plans.

The inspector spoke with the incoming person in charge and the area manager about the arrangements in place to supervise staff in this centre. They confirmed that all formal staff supervision sessions had not been carried out in line with the provider's policy. However, since both these individuals had commenced/returned to their roles in recent weeks clear efforts had been made to rectify this. Some of these overdue supervisions had occurred and all were scheduled to take place in the weeks following the inspection. The inspector viewed a small sample of supervision records that had been completed in the previous week and saw that pertinent issues such as safeguarding and staff training were discussed. The incoming person in charge also told the inspector that team meetings had not been occurring in recent months but these had recommenced since they had taken up the role of person in charge and she told the inspector about the plans to schedule these regularly going forward. Staff spoken to on the day of the inspection confirmed that they had taken part in formal supervisions and that they were well supported by all of the management team, including senior management. Staff told the inspector that they were comfortable to escalate any concerns that they might have and that concerns or issues that were escalated to management were taken seriously and acted upon.

The CNM1 and social care worker positions in the centre were intended to provide supports to the person in charge to maintain full oversight of the centre and to support the person in charge with the day-to-day administration and running of the centre. The vacancies in these key roles was seen to impact on the overall oversight of the centre, particularly at times when the role of the person in charge was changing or the person in charge was absent. For example, staff supervisions had not been completed as per the schedule and some further work was required to ensure that staff training was up-to-date. Some actions identified in provider audits had not been completed in full. For example, it was seen that care plan audits had commenced in November 2022 but had not been continued and this meant that ongoing non complaince in relation to personal plans was not being identified and managed. Also, there was ongoing non-compliance in relation to the notification of incidents as required to the chief inspector and a number of required notifications had not been submitted in the previous year. It was clear from the documentation viewed during this inspection that the incoming management team had made substantial efforts to address some of these deficits and were committed to bringing

this centre into compliance with the regulations.

A sample of staff files viewed by the inspector showed that the relevant information and documents to be obtained in respect of staff employed in the centre was present. Documentation viewed during the inspection indicated that overall the required information was maintained in respect of residents. A copy of the statement of purpose, residents' guide and inspection reports were also available in the centre. No complaints had been recorded in this centre in the previous year.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Registration Regulation 5: Application for registration or renewal of registration

An application to renew the registration of the designated centre had been submitted by the provider. Not all of the information provided was up-to-date.

Judgment: Substantially compliant

Regulation 15: Staffing

The registered provider had made efforts to ensure that the staffing arrangements in place were appropriate to the the number and assessed needs of the residents in this centre. For example, some residents personal plans had were not being reviewed regularly. A sample of staff files viewed were seen to contain the appropriate information as specified by the regulations. Agency records were viewed and while some records were not available on the day of the inspection, evidence of staff training and appropriate Garda vetting was viewed. A regular core staff team worked in the centre providing continuity of care to residents. A staff rota was maintained in the centre. Some staff vacancies remained, including some key local management roles and this was having an impact on some aspects of the service such as oversight of documentation. This will be dealt with under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training records were viewed. Staff in the centre had access to a variety of relevant training appropriate to their roles. However, not all staff training was in

date. For example, records viewed indicated that five staff required refresher fire safety training and eight staff required training or refresher training in the management of actual and potential and aggression (MAPA). Some of this training had been booked and the incoming person in charge and area manager were making efforts to ensure that all staff had up-to-date training. A supervision schedule was in place but all staff had not received formal supervision in line with the provider's policy.

Judgment: Not compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre and was made available to the inspector. This contained most of the required information specified in the regulations. However, some of the details pertaining to residents' addresses was inconsistent. This was brought to the attention of the management of the centre during the inspection.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had in place insurance in respect of the designated centre as appropriate.

Judgment: Compliant

Regulation 23: Governance and management

The management team of the centre had recently changed and there had been periods of time where local oversight had been impacted by changes in management. The incoming person in charge and person participating in management were seen to be providing oversight in this centre at the time of the inspection. An annual review had been completed and included consultation with family members of residents. Provider six monthly unannounced visits were occurring as appropriate and there was an auditing system in place. Some staff vacancies, including some key local management roles, was seen to have impacted on some aspects of the service such as oversight of some documentation and delays in providing formal staff supervision and training. Also, there was some ongoing non-compliance in relation to the notification of incidents and personal plans and

some of the information provided in respect of the application to renew the registration of the centre was incorrect.

Judgment: Not compliant

Regulation 3: Statement of purpose

The designated centre's statement of purpose had been submitted to the chief inspector as part of the application to renew the registration of the centre. This document contained the required information as set out by the regulations and described the facilities and services to be provided in the centre. The inspector also viewed a copy of this document in the centre. Some minor amendments were required and these were completed on the day of the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents had been reported as required. The inspector was informed that a recent safeguarding incident had not been notified within the required time period. This was submitted retrospectively. Also, some quarterly notifications had not been submitted in respect of the third quarter of 2022 and some restrictive practices in place in the centre had not been identified and reported as required.

Judgment: Not compliant

Quality and safety

The wellbeing and welfare of residents was maintained by a good standard of evidence-based care and support. Overall the evidence showed that safe and good quality supports were provided to the residents that lived in this centre and availed of respite services there. However, some improvements were required in relation to the documentation in place around personal plans, restrictive practices and positive behaviour support in the centre. .

A sample of personal plans were viewed. A previous inspection had found that residents were not always involved in their own person centred planning (PCP) meetings. This inspection found that resident involvement in these meetings remained limited. The inspector acknowledges that some residents may choose not to partake in these meetings, but there was limited evidence to show that attempts

were being made to involve and consult with residents in this process. Some of the plans viewed showed that residents were being supported to set and achieve goals. However, no meaningful long term goals had been identified for one resident in the sample viewed. Another part-time resident, who had spent a significant amount of time at home with family during the COVID-19 pandemic, was seen to not have had a multidisciplinary review or PCP meeting since returning to the centre a year ago. The last documented MDT review and PCP for this resident was dated in 2019. Although these reviews had not been completed, the inspector did see that where support plans required updating or review, this had been completed, There was also evidence that the resident was accessing appropriate health and social care supports and was partaking in activities and provided with appropriate care when they were present in the centre.

Staff spoke about one resident going farming one day a week and plans for another resident to gain work experience with the maintenance department. Other activities residents enjoyed included basketball, horse-riding in the adjoining equine therapy centre, swimming, hill-walking and going out to eat. Numerous photographs were on display throughout the centre and in individual apartments that showed residents enjoying activities of interest to them such as trips to the beach, scenic walks and viewing tractors. Many of the residents in this centre availed of day services and were supported to attend these.

Practices in this centre were observed to be person centred. However, some of the documentation in place required review to ensure that the guidance provided to staff was up-to-date and would ensure that residents' rights were upheld at all times. Behaviour support plans were seen in a sample of resident files viewed. On reviewing the support plans in place for a resident the inspector saw that one of these was in place to encourage a resident to attend their day service on site and enhance task completion. The wording on this support plan indicated that the resident would be discouraged from returning to their residential service during day service hours by restricting access to certain areas of the designated centre, withdrawing social interactions and limiting the residents' access to specific personal care supports. There were clear benefits to the resident attending their day service and taking part in the activities provided there and there was not always a staff member present in the centre during day service hours. However, the wording on this support plan was not rights-based or person centred and did not take into consideration the residents' personal choice in relation to how and where they spent their day or provide a clear rationale for the restrictions that would be imposed on the resident, were this plan implemented as described. The inspector discussed this with management of the centre and was told that the resident would not be denied any basic care or attention if they chose to return to the centre during day service hours. They also told the inspector that staff were not adhering to this plan as described. The inspector did observe this resident returning to the centre on a number of occasions during the day and saw that they were free to move around the centre and were appropriately responded to by staff and management. The daily records viewed relating to this resident also indicated that their ongoing care and support needs were attended to by staff and did not reference the use of any of the restrictions mentioned in the support plan.

Risk management procedures were in place to ensure that any risks identified were mitigated against. Risk was being appropriately reviewed and where appropriate, risks were being escalated. For example, the risks posed by staff shortages had been documented and reviewed. During a period when staffing levels in the centre were poor, this risk had been escalated and a plan put in place to mitigate against the risk. The risk attached to this had subsequently reduced as staffing levels improved and this was reflected in the risk assessment in place. A recently completed infection prevention and control self-assessment tool had been updated in February 2023. This had identified some actions and there was evidence these were being completed. For example, this had identified that hand hygiene audits were not being completed regularly and the inspector saw that two such audits had been completed since then.

Overall, based on the observations of the inspector and the residents and staff spoken with, the inspector saw that the care and support of residents in this centre was good and centred around individual needs and preferences. However, this was not consistently reflected or evidenced in the documentation in place in the centre, although some recent improvements in this was evident.

Regulation 13: General welfare and development

Residents were seen to be well supported in this centre in line with their assessed needs and wishes. Residents had access to facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests, capacities and developmental needs. There was evidence that residents were supported to attend a variety of activities including community based activities. Residents were supported to maintain personal relationships.

Judgment: Compliant

Regulation 17: Premises

The designated centre was seen to be clean and maintained to a good standard throughout. The centre was designed and laid out to meet the aims and objectives of the centre. Individual apartments and communal areas were personalised to residents' preferences and the centre. The centre was seen to be accessible to the residents that lived there.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents had access to a variety of home cooked meals and snacks and were supported with dietary requirements. Residents had access to snacks, drinks and refreshments in their own apartments. Some residents were supported to complete their own grocery shopping. Speech and language therapy input was available to residents where required if a swallow care plan was required.

Judgment: Compliant

Regulation 20: Information for residents

An appropriate residents guide was in place. Some minor amendments were made on the day of the inspection to ensure that all of the information was up-to-date and it accurately reflected the services provided in the centre and this was shown to the inspector prior to leaving the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a local risk register in place. This identified a number of risks and had been recently reviewed. Risks associated with staff shortages in the centre had been identified and escalated as appropriate. The provider had in place a risk management procedure in place and this included details of risk that are required to be assessed under the regulations.

Judgment: Compliant

Regulation 27: Protection against infection

Infection control procedures in place in this centre to protect residents and staff were seen to be in line with national guidance. The premises was observed to be clean and appropriate hand washing and hand sanitisation facilities were available to staff, residents and visitors. The centre was overall well maintained and appropriate control measures, such as cleaning schedules and the appropriate use of PPE, were in place to reduce the probability of residents being exposed to infectious agents. Appropriate guidance was available to staff.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

One resident, who had spent a period of time at home during the COVID-19 pandemic, had not had an MDT review or PCP meeting since 2019, despite having returned to the centre the previous year. While there was evidence that some residents had personal plans and these had been recently reviewed with goals being set and achieved, some other residents had not taken part in an annual review of their plan and had not been supported to set meaningful goals in line with their assessed needs.

Judgment: Not compliant

Regulation 6: Health care

A sample of records viewed relating to healthcare in this centre showed that residents were supported to access appropriate healthcare. Where residents required specific supports in relation to their healthcare, appropriate support plans were in place. Residents had access to a variety of healthcare professionals, and had access to mental health and nursing supports if required.

Judgment: Compliant

Regulation 7: Positive behavioural support

A sample of records relating to restrictive practices was viewed. Restrictions in place were seen to be regularly reviewed by a multi disciplinary team and there was a clear rationale in place for them. There were documented efforts to reduce or remove restrictions where possible.

Behaviour support plans were in place for residents.These were comprehensive and overall provided good guidance for staff working in the centre. Staff had access to appropriate training. Some staff were overdue refresher training in MAPA-this has been dealt with under Regulation 16: Staff Training and Development.

Judgment: Compliant

Regulation 8: Protection

Staff and management spoken to were clear on their responsibilities in relation to safeguarding in this centre and all staff had taken part in appropriate training in this area. Staff told the inspector about the steps they would take should they have a safeguarding concern. Where incidents of a safeguarding nature had occurred, appropriate action was taken to ensure that residents were protected and there were efforts made to ensure that incidents did not reoccur. Intimate care plans were viewed in a sample of residents' files.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were offered choices in this centre in areas such as food, activities and how they personalised their physical environment. Staff were observed to speak to residents in a respectful manner. Staff spoken to during the inspection presented a positive overview of residents and their lived experiences, and had a strong awareness of residents' preferences and communication styles. Some of the documentation in place required review to ensure that the guidance provided to staff was in line with best practice and would ensure that residents' rights were upheld at all times.

Judgment: Substantially 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	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Liskennett Centre OSV-0004263

Inspection ID: MON-0030892

Date of inspection: 04/04/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: The Provider corrected the application documentation and resubmitted same to HIQA on May 25th2023. The provider will ensure for future submissions that the documentation submitted will be up to date and correct.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Provider can confirm that the 5 staff identified during the inspection have now completed their Fire Safety training. Likewise the Provider can confirm that the 8 staff identified during the inspection have completed their MAPA refresher training. Monitoring of all staff training is done by the PIC on a regular basis using the training matrix. The Provider has a plan in place to ensure all supervisions will be up to date by August 14th 2023.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Provider can confirm that the incorrect addresses identified within the Directory of Residents have been corrected	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

There is a plan insitu to ensure all supervisions will be up to date by August 14th 2023.

To ensure compliance with Regulation 23, the Provider through both the Person in Charge and Person Participating in Management will monitor and ensure all supervisions will be completed as per policy.

Outstanding notifications of incidents were retrospectively submitted. To ensure compliance with this requirement, notification of incidents will form part of the Quality monitoring program.

Personal plans are currently under review by the Key worker and will be completed by August 7th 2023.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
As clarified by the PIC with the Inspector on June 20th 2023, it was only the NF39A notification that was not submitted.
The safeguarding incident in question was submitted on the day of inspection, April 14th.
To ensure compliance with regulation 31, the PIC will ensure that all notifications are submitted within the required timeframe.
Regarding the reference to restrictive practice, the Provider can confirm that all residents have keypads on their apartment doors. All residents are fully component in gaining access to their individual apartments.

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:
Regarding the outstanding PCP and MDT, the Provider can confirm that a PCP meeting was held on May 12th 2023 and goals set in line with residents assessed needs.
The annual MDT review is scheduled for July 25th in which all residents will be given the opportunity to partake in same and contribute to their goal setting.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The provider can confirm that documentation has now being reviewed (May 2023) in line with best practice to ensure residents rights are upheld at all times

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	23/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	14/08/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	14/08/2023

Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	23/06/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	14/08/2023
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/07/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any	Not Compliant	Orange	31/07/2023

	occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/07/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, 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.	Not Compliant	Orange	23/06/2023
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a	Not Compliant	Orange	25/07/2023

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	25/07/2023
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his	Substantially Compliant	Yellow	23/06/2023

	or her care and support.			