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:	Edencrest, Riverside & Cloghan Flat
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Short Notice Announced
Date of inspection:	02 March 2021
Centre ID:	OSV-0005487
Fieldwork ID:	MON-0030793

About the designated centre

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

Edencrest. Riverside and Cloghan flat provides full-time residential care and support to up to thirteen adults with a disability. The designated centre comprises of two six bed bungalows and a one bedroom flat located within a campus setting which contains three other designated centres operated by the provider. Residents in each bungalow have their own bedroom and have access to a small kitchenette, dining room, two sitting rooms, clinic/visitors room and bathroom facilities. Meals are prepared and cooked in a centralised kitchen on the grounds of the campus and delivered to each house at specific times throughout the day. The centre is located in a residential area of a town which is in close proximity to amenities such as shops, leisure facilities and cafes. Residents are supported on a 24/7 basis by a staff team of both nurses and health care assistants. There is also a person in charge of the centre who also has a management remit to the entirety of the campus.

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 - 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 2 March 2021	09:45hrs to 16:45hrs	Thelma O'Neill	Lead
Tuesday 2 March 2021	09:45hrs to 16:45hrs	Angela McCormack	Support

What residents told us and what inspectors observed

Overall, inspectors found that there were mixed experiences of what it was like to live in the centre depending on what location of the designated centre that residents lived in. There were compatibility issues in one house which impacted on the quality of life for all residents who lived there; while residents living in another house and apartment that formed part of the centre appeared to have a good quality of care and support which met their individual needs.

The designated centre comprised two houses and one apartment, all of which were based on a congregated setting. Two houses accommodated six full-time residents, with one resident living alone in their own apartment. At the time of inspection, there were five residents living in one house, six in another house and one resident in their own apartment. During this time of the COVID-19 pandemic, inspectors spent time reviewing documentation and meeting with the person in charge and staff in a room that was not part of the designated centre and where physical distancing could be maintained. Inspectors did not get the opportunity to meet with residents who lived in one house at this time; however they spoke with staff who were familiar with residents' needs and could give an account of what residents' experiences of living there was.

Inspectors got the opportunity to speak with two residents, one who lived in their own apartment and one who resided in a house with four other residents. One resident spoke with inspectors through a telephone call, and another resident was happy to meet and speak with an inspector at their front door, where the inspector ensured that public health advice was followed including; physical distancing, limiting time spent with them and the wearing of a face mask.

In general, residents spoken with appeared happy and content with the supports and services provided. One resident spoke about their experiences at this time saying that they missed their day service. They informed the inspector about activities that they were doing at this time including; going on the bus for local drives, watching television, going for walks and playing basketball in their garden. They spoke about a new wheelchair that they had got that day and said that they would be trying it out later that day. They also spoke about their bed and explained how they could lower and raise it which helped them to safely use it, and said that they enjoyed watching television in bed in the mornings. They also said that they liked going to sports events and had done this prior to the public health restrictions.

Another resident informed the inspector that they had spent the morning out on their bike and that they enjoyed this. The resident said that they were happy with the level of staffing supports provided both day and night, and said that at the times that they were alone they could call staff for support if they needed this. They informed the inspector about their involvement in meetings about their care and support, and also mentioned about having weekly meetings with staff where they made choices about their life. The resident said that they were missing going home

to family at this time, and said that they keep in touch with family members via telephone.

Both residents spoken with said that they liked living at the centre and that they felt safe and well supported by staff. Residents appeared to have good awareness about COVID-19 and spoke about wearing face masks if they were going into shops. One resident spoke about a video which they had made during the pandemic about COVID-19. When asked, one resident said that they would go to staff if they were unhappy about something, adding that they were happy with everything at the moment. Another resident spoke about issues that they had raised in relation to noise levels coming from an adjacent building which they said was 'going on day and night', and also spoke about a request that they had made last year for a tree outside their home to be cut down. They said that staff were following up on the noise issue on their behalf, and added that they had not a recent update in relation to the tree issue and that this had not been addressed.

Inspectors spoke with two family members through telephone calls as part of the inspection. Families were complimentary about the care delivered to their family members. In addition, inspectors met and spoke with three staff members who were working on the day. Staff members appeared knowledgeable about residents' support needs, likes and personal preferences. In addition, staff who inspectors observed supporting residents were noted to be treating residents with dignity and respect, and residents appeared comfortable and happy around staff. Staff members told inspectors their views about how residents were getting on at this time, with consistent information given that there were compatibility issues in one house which affected the quality of life for residents who lived there.

Inspectors did not get to visit the house which accommodated six residents at this time. However, a review of documentation and discussions with staff who were familiar with residents indicated that there were compatibility issues in this house. One resident was noted to have had a deterioration in their mental health in recent years, and while multidisciplinary supports and input had improved since the last inspection by the Health Information and Quality Authority (HIQA) in August 2020, serious issues of concern remained. This resulted in a significant level of incidents occurring in the house due to the resident's distress.

This impacted on all residents living there and affected their right to freely move around their home as they wished. In addition, it was noted that the resident who required supports with behaviours of concern ate their meals alone and also spent much of their time alone in their bedroom. It was further noted that they had increased difficulties in transitioning, including leaving the house, which meant that they spent the majority of their time in the home that they shared with five others. The provider had identified through their auditing systems the trends relating to incidents, and had identified months and times of the day where incidents increased significantly. However, it was not clear from the analysis of incidents how the impact of the lives of all residents who lived there was monitored; including the person who was displaying high levels of distress and behaviours of concern.

A review of documentation and discussions with staff indicated that residents were

negatively affected due to ongoing episodes of distress witnessed. It was noted and inspectors were informed that concerns had been raised through the safeguarding process about the psychological impact on residents; however the plans in place did not sufficiently address the high level of distress experienced by the person displaying the behaviours of concern, or the residents who were witness to almost daily episodes of aggression and distress in their home; which included overturning of furniture, physical threats and intimidation towards residents and staff and banging of doors in the house. This will be discussed further in the following sections of the report.

Overall, inspectors found that residents' experiences of their home differed depending on what part of the centre they lived in; with some residents saying that they felt satisfied with supports and felt safe, and others reported to be living in an environment where frequent incidents of aggression and distress were displayed which impacted on their quiet enjoyment of their home. The next sections of the report will discuss further the governance and management arrangements in place and how these arrangements impacted on the quality of service being delivered to residents.

Capacity and capability

On this follow-up inspection, inspectors found the provider did not demonstrate that they had the capacity and the capability to deliver a safe quality service in Edencrest, Riverside and Cloghan flat designated centre, as there continued to be a significant number of non-compliance's identified in the centre.

This inspection was conducted as a follow-up risk inspection following the poor findings on the last inspection in August 2020. On the last inspection of this centre, five non-compliance and three substantial compliance were identified, specifically related to behaviours of concern occurring in the centre and their impact on residents' rights, protection and the governance and management of the centre. These risks were the focus of this follow-up inspection and the provider's response to address these risks.

The provider of this service was the Health Service Executive (HSE), and they had a clear governance structure in place to manage this centre. However, the provider had not ensured that their governance and management systems effectively monitored and provided a safe service for all residents, as the person in charge; although supported by a Clinical Nurse manager (CNM2), was also responsible for the whole campus settings as the Acting Director of Services as well as a second designated centre on the campus which effected her ability to have a physical presence and effective oversight to monitor the operational management and administration of the designated centre.

On the day of the inspection there were ten staff working in the centre during the day, and four staff at night. Inspectors found that the provider had ensured that the

number, qualification and skill mix of staff working in the centre were suitable to meet the care and support needs of the residents. However, staff were frequently required to support other designated centres on the campus, which affected the continuity of care for the residents. This was also identified on the last inspection and had not yet been addressed, however, inspectors were informed that the provider was aiming to complete this by June 2021.

Inspectors reviewed the actions from the last inspection and found that the provider had not taken adequate measures to address those risks identified, particularly in relation to Riverside within in the centre. Risks relating to the management of residents' needs in the centre had deteriorated, and incidents of self-harm, physical and psychological abuse towards staff and residents had increased to a daily occurrence in the centre. Inspectors found that although safeguarding risks had been escalated to the provider through the incident reporting system, and scheduled monthly safeguarding meetings had occurred, there was no long-term strategy in place to resolve the risks or address the compatibility of residents which was the main source of concern in the centre. For example, the person in charge told inspectors that they were planning to reduce the numbers of residents living in the centre by moving one resident to another location on the campus; however, the person proposed to move house was not the person of concern who was unsuitably placed in the centre. Therefore, inspectors were not assured that this plan would resolve the protection issues and reduce the risks to others at the centre.

The provider had systems in place to monitor and review the quality and safety and risks in the centre and had completed an annual review and two six monthly unannounced audits of the centre. Inspectors found that the provider's auditing process was robust in terms of identifying residents' views of the service, risks and operational and management issues, but they were not effective in addressing practices requiring improvement at the centre, with many of the actions identified not being addressed, despite them highlighting significant risks in the centre.

The inspectors told the provider representative and the management team at the feedback meeting that they found two out of the three houses in this designated centre was mostly compliant and had received positive feedback from staff and residents in these houses. However, there were significant risks identified which were comparable with those of the previous inspection of the centre on the 18 August 2020, which had not been addressed and impacted on compliance levels at the centre. The provider representative acknowledged the issues and said that the provider was aware of the risks in the centre, and they had put some allied health supports in place since the last inspection. However, they had no available residential placements or funding for new services to move the resident to, but advised the inspectors the risks had been escalated to the chief officer in the HSE.

Regulation 14: Persons in charge

The person in charge of this centre was also the Acting Director of Services for the

campus, which required her to have additional responsibilities and impacted on her ability to have effective oversight and to monitor the operational management and administration of the designated centre.

Judgment: Substantially compliant

Regulation 15: Staffing

Staff were frequently required to support other designated centres on the campus, which affected the continuity of care for the residents. This was also identified on the last inspection and had not yet been addressed, however, inspectors were informed that the provider was aiming to complete this by June 2021.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place were not effective as they did not ensure there was adequate managerial oversight of the centre by the provider or the person in charge on a regular and consistent basis to ensure residents' safety, and their care and support needs were effectively managed. The provider did not ensure the service was resourced to effectively respond to the compatibility issues in the centre and the individual care and support needs of residents.

Judgment: Not compliant

Quality and safety

The inspector found that significant improvements were required in the quality and safety of care provided to residents in this centre. Since the last inspection, several serious risks and safeguarding incidents had occurred in the centre that had impacted negatively on residents' safety and quality of life.

Inspectors found that there was good quality of care provided to residents in two houses in this centre; however, significant improvements were required in the quality and safety of care provided to the six residents residing in Riverside. There was a consistent pattern of serious incidents of self-harm, aggression and violence towards staff and safeguarding incidents towards peers occurring in the centre. These incidents had significantly impacted on the residents' safety and quality of life, despite additional supervision being put in place to protect residents. The provider

was aware of these ongoing risks in the centre, but had not addressed these issues to ensure resident safety.

Inspectors reviewed the actions of the last inspection on the 18 August 2020. The provider had completed a multidisciplinary review in January 2021 for the resident of concern. Although they identified actions to increase additional multi-disciplinary supports, there was no recommendation to relocate the resident to a more suitable environment to address their needs and the serious risks occurring in the centre. Inspectors found the actions taken by the provider did not ensure they protected residents' or staff safety at the centre.

Inspectors found that there were a significant number of incidents relating to Riverside and specifically relating to one resident displaying self- harm, violence and aggression outbursts. In February 2021, incidents sampled included the overturning furniture, throwing items, banging doors, hitting staff and residents. Environmental control measures were implemented in response, however described behaviours coupled with implemented restrictions impacted on all of the residents in the centre, furthermore there was no strategic plan in place to rectify these issues in the long-term. A review of the resident's individual assessment and personal plans showed that they were not suitability placed in this centre. The premises and the associated environment was identified as one of the key issues that were negatively impacting on resident's behaviour, and as a result, many restrictive practices and control measures were in place to manage risks associated.

This issue was identified at the last inspection by the Health Information and Quality Authority (HIQA) and subsequently HIQA was provided with assurances by the provider that they would conduct a multi-disciplinary team assessment, provide allied health support to residents and the staff team, and safeguarding meetings would occur fortnightly. However, the person in charge told inspectors that although occurring safeguarding meetings continued to be only held monthly.The manager who was also the designated officer for safeguarding and told inspectors that they had reported protection risks to the national safeguarding and protection team due to concerns for the safety of residents, but there has not been a robust response to address this risk. Inspectors found that there were safeguarding plans in place for five residents in this centre, but the safeguarding plans did not have a robust action plan in place to safeguard residents from the frequent abuse and upset they experienced at the centre. Furthermore, safeguarding plans shown to inspectors were interim plans and had not been updated since they were developed in August 2020. In addition, inspectors found several incidents of unexplained bruising to residents, with one incident not being subject to a preliminary safeguarding screening and referral to the resident's GP for review.

Inspectors reviewed the care plans and assessments of need for a number of residents and found that although there was a lot of data and records maintained in residents' personal files, they did not identify the supports and interventions required for residents at risk, or when residents' care and support needs changed. This included; communication plan, behaviour support plan and risk assessments around safety issues that had been identified. In addition, inspectors found that a resident who was admitted to the centre in September 2020, did still not have a

personal plan in place, which is required within 28 days of admission to the centre under the regulations. Inspectors also found residents' needs were not appropriately reviewed as and when required to assess their changing needs and circumstances in the centre.

In addition, not all residents were appropriately supported to participate in a review of their care and support needs in accordance with their wishes to determine if they were satisfied with the level of support or their current living arrangement in this centre. Furthermore, one resident had no day placement and it was identified as an unmet need in their care notes and there was no plan in place to address same.

Inspectors found that there was a high use of PRN (as required) medication used in the centre. For example; one resident had received PRN medications on 63 occasions in the previous three month period. On review, although the protocol stated to administer the PRN for 'agitation' it was not clear what the exact criteria was to determine what 'agitation' was, that required the administration of this medication, and it was very subjective to individual staff's judgments and required review to ensure medication was administered only in the last resort and was the least restrictive measure.

Since the last inspection, the resident of concern had a behaviour support plan updated in February 2021 which identified that the behaviours of concern were most likely the resident's method of communicating that they wanted to avoid a demanding situation, or environmental reason. The support plan was a colour coded traffic light system which guided staff on how to manage the resident's behaviours of concern, which was clear and easy to read. Inspectors found that the behaviour support plan prescribed physical restraint as a method of managing aggression and violence in the centre to prevent physical injury to staff; however, when asked for the protocol for using the physical restraint, the manager told inspectors they did not have one, as she was not aware that physical restraint had been prescribed for this resident and they had not used it in the centre. She also confirmed staff did not have up-to-date training in positive behaviour support and the correct method of using physical restraint. Furthermore, the behaviour support plan recommended using therapeutic interventions such as alternative communication systems as recommended by allied health professionals, but these were not being used, as staff had not received the training in developing these communication systems.

The provider has systems in place for the assessment, management and ongoing review of risk, which included individual risk assessments and the centre risk register. However, although the risks in the centre were identified by the staff to the management team, the risk control measures in place were not proportional to the risks occurring in the centre and the adverse impact these measures were having on the residents' quality of life.

On the last inspection, the inspector found many of the residents in this centre needed support in communicating, and they did not have communication assessments completed. Since then the provider had arranged a communication assessment for one resident in the centre, but the recommendations of the Speech and Language Therapist had not been implemented. For example, they

recommended the use of a visual aid system, such as Picture Exchange Communication System (PECS) and TEACCH communication system (Treatment and Education of Autistic and related Communications Handicapped Children). The Speech and Language therapist also recommended training for staff on these systems, but this training had not been provided to staff. The Speech and Language Therapist also recommended an Occupational therapy Sensory Assessment for the resident of concern, to assess if the resident's environment could be changed to support them better, there was no evidence this had occurred, or it had, that any recommendations were being implemented in the centre. These communication aids, the sensory assessment and staff training supports were urgently required, as there was no plans to relocate the resident to a low arousal environment and the resident needed support to communicate their needs more effectively and to help reduce behaviours of concern in the centre. In addition, the provider had not identified the need to complete communication assessments for the other residents in the centre, despite some of them also having communication difficulties.

In general, residents had access to allied health professionals in the centre; such as General Practitioners, Clinical nurse Specialists, Speech and Language Therapists; however, some professionals had a long waiting list for assessments and treatment. This has been actioned under communication. Inspectors found residents had received assessments for medical equipment and saw that one resident had received a new wheelchair on the day of the inspection. Residents had also received up-to-date information on the COVID-19 pandemic and they were aware of the reason for visitors' restrictions and the use of personal protective equipment (PPE) in the centre.

On the day of the inspection, a COVID-19 outbreak occurred in the centre. While infection prevention and control practices and procedures were in place, some gaps are identified in the documentation that did not ensure that there was a clear procedure in place to manage infection control outbreaks on the campus and the isolation unit in the community.

On the last inspection, inspectors found non-compliances in relation to the premises such as its institutional design and layout of the centre. In addition, the residents access to choice around food preparation and the lack of independence for residents around meal times was identified as an issue. On this inspection, inspectors found this continued to be an issue, as the provider had not provided any evidence that they were addressing this issue in terms of changing the physical layout of the centre, or reviewing the impact it was having on residents' rights, freedom and independence in their home. For example, there was a centralised kitchen in the campus providing meals to four designated centres and meals were delivered to the centre twice daily. Furnishing was also identified as requiring replacement on the last inspection, and the nurse manager confirmed to inspectors that these furnishing had been replaced since the last inspection.

Overall, inspectors found that the rights of all residents were not protected in this centre, as their safety, privacy and dignity and independence were not respected in Riverside, in relation to their personal living space, personal communications, and relationships with their peers. Furthermore, residents did not have the freedom to

exercise choice or control in their daily lives due to the need for safeguarding measures requiring staff to supervise them at all times to protect them from the risks posed in the centre.

Regulation 10: Communication

While the provider had arranged a communication assessment for one resident in the centre, the provider had failed to implement the recommendations of the Speech and Language Therapist in a timely manner. For example: the use of

- A visual aid system, such as Picture Exchange Communication System (PECS)
- TEACCH communication system (Treatment and Education of Autistic and related Communications Handicapped Children).
- Staff training on these systems
- An occupational therapy Sensory Assessment were outstanding.

In addition, the provider had not identified the need to completed communication assessments for the other residents in the centre, despite some of them also having communication difficulties.

Judgment: Not compliant

Regulation 17: Premises

The design and layout and facilities of the premises did not meet the aims and objectives of the service, and the number and needs of the residents. In addition, the premise did not promote the full capabilities and independence of the residents, as the kitchens were not designed to provide all of the meals for the residents daily, and residents had to received their meals from a centralised kitchen, which impacted on their homely atmosphere, and limited their ability to choose or enjoy their preferred food.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems in place for the assessment, management and ongoing review of risk. However, the risk control measures in place were not proportional to the risks occurring in the centre and the adverse impact such measures were having on the residents' quality of life.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While it is evident that infection prevention and control practices and procedures were in place in this centre, some gaps were identified in the documentation as they did not ensure there was a clear procedure in place to manage infection control outbreaks on the campus and the isolation unit in the community.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Inspectors found that a resident was admitted to the centre last September, but their personal plan was not in place, which was required within 28 days of admission to the centre. Inspectors also found residents' needs were not appropriately reviewed as required to assess their changing needs and circumstances in the centre.

Some residents were not appropriately supported to participate in a review of their care and support needs in accordance with their wishes to determine if they were satisfied with the level of support or their current living arrangement in this centre. Furthermore, one resident had no day placement and it was identified as an unmet need in their care notes and there was no plan in place to address same.

Judgment: Not compliant

Regulation 6: Health care

In general, residents had access to allied health professionals in the centre such as General Practitioners, clinical nurse specialists and speech and language therapists subject to availability and waiting list for assessments and treatment.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider did not make every effort to identify and alleviate the cause of

residents' challenging behaviour, and the supports in place were not sufficient to reduce the risks in the centre. Some staff did not have up-to-date training in managing behaviours of concern in the centre. Behaviour support plans were not effective in the management of behaviour-related incidents at the centre which had significantly increased to a daily occurrence at the centre. Furthermore, there was no oversight and monitoring of the use of restrictive practices in the centre such as clear guidance for staff on the threshold of when to administer PRN medication to the residents.

Judgment: Not compliant

Regulation 8: Protection

Safeguarding plans were not robust in nature and did not effectively protect residents from increased behaviour-related incidents at the centre. Furthermore, safeguarding plans shown to inspectors were interim plans and had not been updated since they were developed in August 2020.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors found the rights of all residents were not protected in this centre, as their privacy and dignity was not respected in relation to their personal living space, personal communications, and relationships with their peers. Furthermore, they did not have the freedom to exercise choice or control in their daily lives due to the need for safeguarding measures requiring staff to supervise them at all times around their home to protect them from the risk of harm.

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 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Edencrest, Riverside & Cloghan Flat OSV-0005487

Inspection ID: MON-0030793

Date of inspection: 02/03/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: In order to bring this centre into compliance the following actions will be taken: 1. The Clinical Nurse Manager 2 of the centre is assuming the role of Person In Charge, reporting to the Director of Nursing. Completion date: 23.04.2021 2. The governance of the centre will be further strengthened by the appointment of a Clinical Nurse Manager 1 to support the Person In Charge. The recruitment process in under way with a Clinical Nurse Manager 1 to be appointed by 10.05.2021. 3. In the interim the Person In Charge will be supported by Senior Staff Nurses in the centre and a 0.5 WTE Clinical Nurse Manager 1. The Director of Nursing will meet with the Person In Charge on a daily basis. The Person In Charge will be further supported by the Clinical Nurse Manager 3 for Quality and Service User Safety. The Provider Representative will meet with the Person In Charge on a weekly basis to provide oversight, support and monitor the implementation of the compliance plan. Completion date: 23.04.2021	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to bring the center into compliance the following actions will be taken: 1. Each centre has had an identified and dedicated staffing cohort allocated. Each Clinical	

Nurse Manager 2 is to complete the roster for their centre from the staff cohort. Staff from the centre's staffing cohort will be used for cover purposes. This system will be in place from the week of 26.04.2021.

2. The Clinical Nurse Manager 2, in conjunction with the Director of Nursing and the Provider Representative, will develop a flexible resident centered roster which will ensure that the centre is a stand-alone service with a dedicated staff allocation to support the residents' lived experiences. The proposed roster was completed on 19.04.2021.

3. The Director of Nursing, the Provider Representative and the Human Resource department will consult and engage with staff representative bodies regarding the implementation of the new roster system. Engagement is scheduled to commence on 30.04.2021. The roster will be implemented by 30.06.2021.

4. A review of all vacancies will be undertaken in order to have posts prioritised for recruitment. The review will be completed by 30.04.2021 with a report provided to the General Manager for follow up with HR by the 14.05.2021

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In order to bring the centre into compliance the following actions will be completed:

1. Multidisciplinary compatibility assessment and recommendations will be completed for Riverside. Completion date: 23.04.2021

2. On the basis of a multidisciplinary team assessment, a business case was developed and submitted by the service to the HSE National Head of Disability Operations to support the relocation of one resident to a more suitable environment. Approval was received on the 20.04.2021. A house has been identified, recruitment has commenced and transition preparations are under way as at 21.04.2021. Transition to the new accommodation for this resident will take place by 31.07.2021.

3. In the interim a number of other service locations in the local area will be used to provide all residents with more regular and frequent breaks from their home. These locations can be used for a variety of activities and pursuits on a seven day per week basis. In addition community activities will increase for residents based on their likes and preferences. Reductions in numbers and duration of time spent in the centre will reduce the requirement for restrictions. This action has been implemented as of 19.04.2021

4. A review of all current safeguarding plans will be completed in Riverside 16.04.2021. A review of all safeguarding plans in Edencrest and Cloghan Flat will be completed by

23.04.2021.

5. A robust overarching Safeguarding Plan will be developed and implemented for each resident. A revised process has been put in place in conjunction with the CHO1 Safeguarding & Protection Team to strengthen processes in respect of the provision of supports and recommendations within the plans. All plans submitted by the Designated Officer will be reviewed by the Safeguarding & Protection Team. All revised plans will be completed by 30.04.2021.

6. The Quality Improvement Plan for the centre will be monitored by the Provider Representative and General Manager's office on a weekly basis.

The Provider Representative will visit the Centre on a weekly basis to monitor progress until all actions have been implemented

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication: In order to bring this centre into compliance the following actions will be undertaken:

1. A visual communication system has been implemented for one resident. Training for staff was completed on 26.03.2021 with a second date scheduled for 09.04.2021.

2. A private Speech and Language Therapist has been contracted on a 0.3 WTE basis to the Ard Greine Court services and will provide services as follows:
• Individual assessments of service users where this is clinically warranted. Such assessments will consist of interviews with key staff, reading of reports and medical notes, face-to-face communication assessment of clients, observational assessment of clients and the communication environment, completion of reports
- Assessing and supporting capacity and consent issues
- Feeding into decongregation planning for each service user
- Staff training and follow up support
- The provision of visual materials as needed for residents on the Autism Spectrum
- Attendance at team meetings and staff liaison
- Implementation of recommendations given for each client
- Any additional qualifying work

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
There is a fully accessible kitchenette available, which is equipped with the following:
• Hob
• Grill & Oven
• Microwave
• Toaster
• Kettle
• Fridge/Freezer
• Sandwich Toaster
• Food Processor
• Blender
• Smoothie maker
• Baking equipment and utensils
• Cooking utensils – saucepans, frying pan

Meals are provided for each resident based on assessed need (SALT assessment and dietetic recommendations).
Breakfast is prepared in the centre by residents with support as required. There is a wide range of options available based on individuals' preferred choices.
Dinner and evening meals are provided from a kitchen separate to the centre. There are 2 hot meal options available as well as soup and salads. Residents have access to snacks of their choice within the centre.

In order to bring this centre into compliance:

1. A weekly shopping list is compiled by the Nurse in charge in collaboration with residents at the weekly residents meetings. This will ensure that the centre is always well stocked and can offer a variety of alternative food choices for residents.

2. Residents are to be supported by staff to prepare simple meals in the centre if they wish to do so. This provides residents with an alternative meal option in line with their will and preference.

3. The Head of Disability Service wrote to the Estates department on the 29.03.2021 requesting a preliminary review of the design and layout of the centre kitchen, utility and dining areas and to develop options to reconfigure the centre to ensure it meets the aims and objectives of the service and promotes the full capabilities and independence of residents. The review will be completed by the 31.05.2021.

4. The Provider Representative and the Director of Nursing plan engagement with the Housing Association to discuss and gain agreement on proposed options to adapt the layout of the centre further to review by Estates. Completion date: 30.06.2021

5. In the interim vacant bedrooms and / or room configuration will be reviewed in each centre to support ease of access for residents to the kitchenette and provide a space where snacks and meals can be prepared. The review will be completed by 30.04.2021 and reconfiguration completed by 14.05.2021.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to bring the center into compliance the following actions will be taken:

1. Multidisciplinary compatibility assessment and recommendations will be completed for Riverside. Completion date: 23.04.2021

2. On the basis of a multidisciplinary team assessment, a business case will be developed and submitted by the Disability Service Manager to support the relocation of one resident to a more suitable environment. This is to be submitted to the Head of Service by 28.04.2021

3. A review of all current safeguarding plans will be completed in Riverside 16.04.2021. A review of all safeguarding plans in Edencrest and Cloghan Flat will be completed by 23.04.2021.

4. A robust overarching Safeguarding Plan will be developed and implemented for each resident. A revised process has been put in place in conjunction with the CHO1 Safeguarding & Protection Team to strengthen processes in respect of the provision of supports and recommendations within the plans. All plans submitted by the Director of Nursing will be reviewed by the Safeguarding & Protection Team. All revised plans will be completed by 30.04.2021.

5. A Human Rights Committee will be established to support and provide oversight to the Service. A draft Terms of Reference will be completed by the Provider Representative for all stakeholders by 30.04.2021. The first meeting of the committee will take place by 30.06.2021.

6. The Quality Patient and Safety committee will meet on a monthly basis to review all incidents, assess the impact of these incidents on residents and develop action plans to reduce the occurrence and impact of incidents on residents. Minutes of these meetings are to be submitted to the General Manager on the last Friday of the month as per the weekly QIP monitoring process in place. Dates for the year have been circulated by the Director of Nursing. The Quality and Patient Safety Lead for Social Care and the Clinical Nurse Manager 3 for Quality and Service User Safety will attend. Members of the multi-disciplinary team will also attend and revised Terms of Reference reflect their inclusion. The first meeting is scheduled for 26.04.2021.

7. A Clinical Nurse Manager 3 for Quality and Service User Safety has been assigned to support the Clinical Nurse Manager 2 and Person in Charge in the centre during Quarter 2 and 3, 2021.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
In order to bring the centre into compliance the following actions will be completed:

1. The response and contingency plan has been updated to reflect the procedures in place to manage outbreaks of infections on the campus and specifically when a resident requires to be transferred to the isolation centre.

2. The plan clearly identifies members of the Outbreak team, their roles, how matters are communicated and contingency plans in the event that the isolation centre is at maximum capacity.

3. The plan has been communicated to all staff working in the centre and is to be kept on the agenda at all staff meetings.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
In order to bring the centre into compliance the following actions will be taken:

1. The named nurse and key worker will finalise a personal plan for the resident who was admitted to the centre September 2020 by 15.04.2021.

2. The Clinical Nurse Manager 2 in conjunction with the named nurses will review each resident's personal plan to ensure it reflects current care and support needs based on the will and preference of the resident. Multi-disciplinary team members will be included as part of the review process. Completion date: 31.05.2021

3. Residents are invited and supported by staff to attend their annual review. Residents are invited to have their representative/s attend the review also.

1. If residents do not wish to attend their review the named nurse and keyworker will speak with the resident and ensure their voice is represented at the annual review. This will be documented as part of the review. If a resident's representative/s cannot attend

the review contact is made by the named nurse to seek their input.

2. A process for an annual review with quarterly updating and communication to the resident, resident representative/s and staff will be developed and implemented by 31.05.2021

3. Residents are invited and supported by staff to complete satisfaction questionnaires twice per year. Actions arising from these questionnaires will be followed through by the Clinical Nurse Manager 2. Audits of the questionnaires will be undertaken and an action plan developed based on findings which will be included in six monthly and annual inspections. This will commence by 30.04.2021.

1. Each named nurse and key worker, in conjunction with each resident will develop and implement a meaningful daily activity schedule based on each person's preferences and choice. The activity schedule will reflect a range of options for the resident. Completion Date: 30.04.2021

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In order to bring the center into compliance the following actions will be taken :

1. A review of PRN medication protocols in line with Behaviour Support Plans and Crisis management plans will be completed by the Clinical Nurse Manager 2 in consultation with the Director of Nursing and the Provider Representative and reviewed with the Consultant Psychiatrist to ensure staff are provided with clear guidance as to when PRN medication should be administered. Completion date: 30.04.2021

2. The named nurse will complete an audit of the use of PRN on a monthly basis for identified residents. This will be reviewed each month by the Clinical Nurse Manager 2 and the Director of Nursing. This will be escalated to the prescriber of the PRN medication for review. Completion Date: 28.05.2021

3. The Quality Patient and Safety committee will meet on a monthly basis to review all Incidents, assess the impact of Incidents on other residents and develop action plans to reduce the occurrence and impact. Minutes of these meetings are to be submitted on the last Friday of the month to the provider as per the weekly QIP monitoring process in place. Completion Date: 28.05.2021

4. All residents' Positive behavior Support Plans will be reviewed to ensure that they identify all possible triggers and de-escalation techniques that should be implemented. Completion date: 15.05.2021

5. A schedule for staff training in managing behaviours of concern has been developed by the Clinical Nurse Manager 2. Training has commenced with all staff to be trained by 30.06.2021

6. A Human Rights Committee will be established to support and provide oversight to the Service. A draft Terms of Reference will be completed by the Provider Representative for all stakeholders by 30.04.2021. The first meeting of the committee will take place by 30.06.2021.

7. A Clinical Nurse Specialist for Managing Behaviours of Concern has been made available on a consultative basis to support residents and staff and this will be provided ongoing at a specified time on two days per week.

8. A Clinical Nurse Specialist for Managing Behaviours of Concern has been approved for recruitment. Appointment will take place by 28.05.2021

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In order to bring the center into compliance the following actions will be taken:

1. Multidisciplinary compatibility assessment and recommendations will be completed for Riverside. Completion date: 23.04.2021

2. On the basis of a multidisciplinary team assessment, a business case was developed and submitted by the service to the HSE National Head of Disability Operations to support the relocation of one resident to a more suitable environment. Approval was received on the 20.04.2021. A house has been identified, recruitment has commenced and transition preparations are under way as at 21.04.2021. Transition to the new accommodation for this resident will take place by 31.07.2021.

3. A review of all current safeguarding plans will be completed in Riverside by 16.04.2021. A review of all safeguarding plans in Edencrest and Cloghan Flat will be completed by 23.04.2021.

4. A robust overarching Safeguarding Plan will be developed and implemented for each resident by 23.04.2021. A revised process has been put in place in conjunction with the CHO1 Safeguarding & Protection Team to strengthen processes in respect of the provision of supports and recommendations within the plans. All plans submitted by the Director of Nursing will be reviewed by the Safeguarding & Protection Team. All revised plans will be completed by 30.04.2021.

5. A review of PRN medication protocols in line with Behaviour Support Plans and Crisis Management Plans will be completed by the Clinical Nurse Manager 2 in conjunction with the Consultant Psychiatrist to ensure staff are provided with clear guidance as to when PRN medication should be administered. Completion date: 21.04.2021

6. A schedule for staff training in managing behaviours of concern has been developed by the Clinical Nurse Manager 2. Training has commenced with all staff to be trained by 30.06.2021

7. The Clinical Nurse Manager 2 will review the Guideline on Assessment Analysis Monitoring of unexplained injuries marks or bruises of unknown origin on the body of a vulnerable adult service user with all staff working in the centre at the next governance meeting. Completion date: 16.04.2021

8. Any episodes of bruising will be assessed and investigated in line with this guideline.

9. All unexplainable bruising will be managed by the Safeguarding Vulnerable Adults Policy.

10. An Incident report is completed for all episodes of bruising and a body map completed. Details of all incidents are recorded in residents Nursing notes. All Incident reports are reviewed and signed off by the Clinical Nurse Manager 2 and the Director of Nursing. Further action will be taken as deemed appropriate such as referral to the resident's general practitioner.

11. A Bruising Monitor is maintained for each resident.

12. A retrospective preliminary screening will be submitted to the safeguarding team for one resident with an unexplained bruise by 09.04.2021.

13. A retrospective NF06 will be submitted to HIQA for one resident with an unexplained bruise by 09.04.2021.

14. A Clinical Nurse Manager 3 for Quality and Service user safety has been assigned to support the Clinical Nurse Manager 1 and Director of Nursing in the centre during Quarter 2 and 3, 2021.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: .In order to bring the center into compliance the following actions will be taken:

1. Multidisciplinary compatibility assessment and recommendations will be completed for Riverside. Completion date: 23.04.2021

2. On the basis of a multidisciplinary team assessment, a business case was developed and submitted by the service to the HSE National Head of Disability Operations to support the relocation of one resident to a more suitable environment. Approval was received on the 20.04.2021. A house has been identified, recruitment has commenced and transition preparations are under way as at 21.04.2021. Transition to the new accommodation for this resident will take place by 31.07.2021

3. A review of all current safeguarding plans will be completed in Riverside by 16.04.2021. . A review of all safeguarding plans in Edencrest and Cloghan Flat will be completed by 23.04.2021.

4. A robust overarching Safeguarding Plan will be developed and implemented for each resident by 23.04.2021. A revised process has been put in place in conjunction with the CHO1 Safeguarding & Protection Team to strengthen processes in respect of the provision of supports and recommendations within the plans. All plans submitted by the Director of Nursing will be reviewed by the Safeguarding & Protection Team. All revised plans will be completed by 30.04.2021.

5. A Human Rights Committee will be established to support and provide oversight to the Service. A draft Terms of Reference will be completed by the Provider Representative for all stakeholders by 30.04.2021. The first meeting of the committee will take place by 30.06.2021.

6. Each named nurse and key worker in conjunction with each resident will develop and implement a meaningful daily activity schedule based on each person's preferences and choice. Completion date: 15.05.2021

7. Residents will be supported by staff to prepare simple meals in the centre if they wish to do so. This provides residents with an alternative meal option in line with their will and preference.

8. The Head of Disability Service wrote to the Estates department on the 29.03.2021 requesting a preliminary review of the design and layout of the centre kitchen, utility and dining areas and to develop options to reconfigure the centre to ensure it meets the aims and objectives of the service and promotes the full capabilities and independence of residents. The review will be completed by the 31.05.2021

9. The Provider Representative and the Director of Nursing plan engagement with the Housing Association to discuss and gain agreement on proposed options to adapt the layout of the centre further to review by Estates.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	12/04/2021
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	23/04/2021
Regulation 15(3)	The registered provider shall ensure that	Substantially Compliant	Yellow	26/04/2021

	residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
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.	Substantially Compliant	Yellow	30/06/2021
Regulation 17(5)	The registered provider shall ensure that the premises of the designated centre are equipped, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.	Substantially Compliant	Yellow	30/06/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2021
Regulation	The registered	Not Compliant		30/04/2021

23(1)(c)	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.		Orange	
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	26/04/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	04/03/2021
Regulation 05(3)	The person in charge shall	Not Compliant	Orange	31/05/2021

	ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
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	15/04/2021
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/05/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/06/2021

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	Orange	31/05/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/04/2021
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	Orange	15/05/2021
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the	Not Compliant	Orange	23/04/2021

	knowledge, self-awareness, understanding and skills needed for self-care and protection.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	23/04/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	16/04/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	15/05/2021
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,	Not Compliant	Orange	30/06/2021

	relationships, intimate and personal care, professional consultations and personal information.			