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:	Steadfast House Respite Service
Name of provider:	Steadfast House Company Limited By Guarantee
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	30 September 2022
Centre ID:	OSV-0001632
Fieldwork ID:	MON-0038049

About the designated centre

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

Steadfast House Respite Service is a five bedded home, established in 2010, situated outside a town in Co. Monaghan. Steadfast House Respite Service can accommodate a maximum number of four adult residents per night. The centre provides care for people with low, medium, high and maximum dependency needs. The range of needs that the centre intend to meet for residents are intellectual disabilities including those with complex care needs and physical and/or sensory disabilities. It consists of five bedrooms including two en-suites; bedroom five has an overhead hoist fitted that links to the main bathroom. It also has a kitchen dining area, sitting room and a back kitchen. Steadfast House Respite Service has its own garden to front and back of house, with tiled patio area at back of house with outdoor seating provided. The staffing arrangements include nurses, a social care worker and health care assistants and the staffing rosters are planned in accordance with admissions to the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Friday 30 September 2022	09:25hrs to 17:25hrs	Caroline Meehan	Lead

What residents told us and what inspectors observed

The centre provided respite services for up to four adults at any one time, and was located just outside a large rural town. Residents stayed in the centre for a number of nights at a time, and had their own bedroom when they stayed in the centre. Residents also had use of a centre bus, and staff regularly brought the residents on trips outside of the centre.

On arrival, the inspector saw residents were leaving the centre, and transport was provided to bring them to their day services. The inspector observed that residents were warmly dressed, appropriate to the weather, and that staff were helping them to get onto the bus.

Two residents were discharged on the morning of inspection, and the inspector observed staff thoroughly cleaned bedrooms in preparation for the arrival of two residents for their stay in respite in the afternoon. Similarly in the afternoon, a staff was reviewing residents' personal plans to ensure they knew the residents' needs before they arrived to the centre.

The centre was warm, welcoming and nicely decorated throughout, and each of the residents had individual bedrooms, ensuring they had private space during their stay, and they had enough space to store their clothes and personal items. There was a large homely kitchen, and an adjoining sittingroom, and in the evening the inspector observed that a resident liked to sit in this area. All areas of the centre were accessible, and equipment such as a hoist, handrails and an external ramp, were provided should any resident require them.

From talking to staff and reviewing personal plans, it was clear that residents' stays in this centre were planned as residents wished. Some residents liked to do activities in the centre, and some residents liked to go out and do things in the community. Residents, with the support of staff and information provided by families, had goals for each stay in the centre, and these goals varied from meals out, going bowling, going out for ice-cream, listening to music, bus trips, and going to parks. The inspector found residents were supported with these choices and staff made sure that they were provided with the activities they had requested.

The inspector met one resident in the evening, and while the inspector was not familiar with the communication preference of the resident, the resident appeared happy and relaxed in the centre. Staff were observed to be respectful and kind in talking with the resident.

The inspector spoke to three staff members over the course of the day, and all staff knew the residents well, and were able to describe the care and support they provided to residents to ensure their stay in the centre was safe and enjoyable. Staff also made sure that any concerns they had about the mix of residents in the centre

at any one time, were addressed before residents came to stay in the centre.

However, there were a number of improvements needed in the centre, to ensure that where support for residents was needed that this was provided, for example, staff having the appropriate training to support residents, and providing behavioural support when it was identified as required. Improvements were also needed to ensure that issues were identified through effective monitoring, and that the provider followed through on actions they had identified themselves, to ensure improvements.

The next two sections of the report outline the governance and management arrangements in the centre, and how these arrangements impacted on the care and support residents received in the centre.

Capacity and capability

This risk based inspection was carried out to seek assurances on the governance and management of this centre, and on the quality and safety of services being provided to residents who availed of respite services in the centre.

The inspector found the oversight of this centre required improvement, and there had been inadequate monitoring of the services provided in the centre. While there were some auditing procedures in place, the provider had not completed an annual review of the quality and safety of care and support, and some actions arising from audits were not completed within the stated timeframe. Similarly, six monthly unannounced visits were not completed within the required timeframe.

The arrangement for the person in charge to manage two designated centres, was not appropriate, and impacted on the capacity of the person in charge to effectively oversee the running of this centre.

The management in place had not ensured that appropriate training resources were provided to staff, and there were a number of staff who required refresher training as well as training in positive behavioural support. While staffing resources were in the main sufficient to meet the needs of residents, some improvements were required to ensure staffing levels increased in line with the stated needs of residents.

There was a clear and transparent admission process, and the admission planning procedures took into account the need to protect residents.

Regulation 14: Persons in charge

The person in charge had the required experience and qualifications for the role, and they were employed in a full time capacity. The provider had delegated responsibility for the management of two designated centres to the person in charge.

The centre accommodated up to 70 residents for respite services, and four residents could stay in the centre at any one time. The person in charge attended the centre for a half day every day, Monday to Friday. The inspector was not assured that adequate support had been given to the person in charge since the commencement of their role in April 2022, to ensure they were knowledgeable on residents' needs, Similarly the person in charge did not have sufficient time to enable them to implement the required improvements identified on audits in the centre.

Therefore the inspector found the current remit of the person in charge being responsible for two designated centres, was not ensuring the effective operational management and administration of the designated centre.

Judgment: Not compliant

Regulation 15: Staffing

While the skill mix in the centre was found to be appropriate, improvement was required in the numbers of staff provided at times, in line with the stated supervision levels for residents. For example, one to one support was to be provided for a resident when the centre was at full capacity, and the person in charge confirmed this was in place. However, from a review of the roster and the directory of residents, this additional staff was not provided on three occasions, and staffing levels remained at two staff to support four residents. There were two staff on duty during the day including a nurse and a healthcare assistant. At night time, one staff was on duty, in a waking capacity. The inspector also reviewed staffing arrangements for two residents where specific requirements were stated, and appropriate staffing had been provided for these residents during their stay.

Planned and actual rosters were appropriately maintained.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed staff training records with the person in charge and found that significant improvement was required in the provision of staff training. One staff had not completed training in behaviour that challenges or in specific therapeutic interventions in order to be safely able to support residents in line with their

behaviour support plan. One staff had not completed training in first aid, and refresher training was required for one staff in safeguarding, one staff in manual handling, and for one staff in infection prevention and control.

A recommendation arising from an IPC audit, for all staff to complete specific training, had not been completed.

All staff had up-to-date training in fire safety, hand hygiene, and donning and doffing personal protective equipment.

Judgment: Not compliant

Regulation 23: Governance and management

Improvement was required in the oversight of the centre, to ensure the centre was monitored appropriately, and to ensure actions identified on audits were implemented within the stated timeframe. The provider had not ensured appropriate provision of training resources for staff, and while sufficient staffing was provided most of the time, some improvements were also required.

There was a management structure in place, and staff reported to the person in charge, who reported to the chief executive officer (CEO). The CEO was also nominated as a person participating in management. The CEO reported to the board of directors. The inspector acknowledges that a number of changes to the board of directors and their oversight remit were currently being initiated. However, these changes were only being implemented, and the findings on this inspection reflected inadequate oversight of the services by the provider overall.

The person in charge competed a range of audits and the inspector reviewed these audits and subsequent actions with the person in charge. Audits included, for example, infection prevention and control (IPC), fire drills, and medicine management. While actions had been completed as required for medicine management audits, a recent IPC audit did not have some of the actions completed within the stated timeframe. While the person in charge signed off on all fire drills, there was no evidence to confirm that a comprehensive review of fire safety systems were completed on an ongoing basis. The person in charge stated they did a regular walk around the centre; however, did not keep a record of aspects of fire safety which had been checked.

A six monthly unannounced visit by the provider had been completed in July 2022, however it had been over 10 months since the previous unannounced visit. The person nominated to carry out the visit and review of services, had identified a number of improvements which were required, for example, auditing of incidents and ensuring all incidents forms were completed, this was not satisfactorily completed on the day of inspection. Similarly an action relating to staff training for new staff was not wholly complete on the day of inspection. Some actions had been completed, for example, an IPC audit had been put in place, and some

administrative actions had also been completed.

The provider had not completed annual review of the quality and safety of care and support since 2020.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The person in charge met with an area respite coordinator and community nurses, to plan respite services for residents, and a provisional respite planner was developed. There was a clear and transparent process for admissions to the centre, and two staff members explained to the inspector that all planned admissions were discussed at team meetings, to ensure risks relating to compatibility were mitigated prior to residents staying in the centre.

Residents and their families were provided with a contact of care prior to each admission, which set out the services to be provided. Families were also requested to provide written information on any changes in residents' needs, and staff followed this up with a phone call to families, 48 hours before a resident was admitted to the centre.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure in place. The person in charge was nominated as the complaints officer. The inspector reviewed the complaints log, and no complaints had been received since the last inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

HIQA had not been notified of the use of one environmental restrictive practice, specifically the locking of external gates.

Judgment: Substantially compliant

Quality and safety

The inspector found that for most part, residents were being provided with the appropriate care and support in line with their needs and their wishes, and residents appeared to have positive experiences when staying in the centre. However, improvements were required in the provision of behavioural support, and in the upkeep of the premises. Some improvements were also needed in infection prevention and control, in risk management and in some assessments and personal plans.

Overall residents' needs had been identified and personal plans outlined the care to be provided to residents during their stay in this respite centre. Most assessments and plans were up-to-date; however some improvement was required in the assessment of some residents' healthcare needs, and in the development of some personal plans. Improvement was required in the provision of behavioural support for some residents, to ensure emerging risks related to behaviours of concern were assessed by the relevant professional, to ensure plans were in place to guide practice, and to ensure staff had the required training.

Overall residents were protected in the centre, and safeguarding incidents had been appropriately reported, investigated and managed. The control measures outlined in safeguarding plans were implemented so as to ensure residents were protected.

While there was a system in place for the reporting investigating and learning from adverse incidents, the oversight of risks required improvements, specifically relating to the review of incidents to ensure control measures were consistently implemented.

The premises had sufficient space and facilities to meet the diverse needs of residents who stayed in the centre, however, the upkeep of the premises required improvement. The provider had not implemented some of the action relating to the premises since the last inspection, and painting of some areas remained outstanding with no clear plan on when this would be completed. Similarly, some damage to doors and kitchen presses could not ensure satisfactory cleaning could be completed. Improvement was also required in the storage of used linen.

Regulation 17: Premises

Since the last inspection in December 2021, the provider had not fully implemented the action outlined in their compliance plan relating to upkeep of the premises. For example, significant paint damage was noted to the wall in a bedroom and while the provider had in their previous compliance plan this would be completed in February 2022, there was no clear plan or timeframe on when this work would be completed.

The centre had sufficient space and facilities to meet the needs of the residents who stayed in the centre, and the assistive equipment such as hoists, an external ramp, and profiling beds were provided. There were adequate numbers of bathrooms, and sufficient cooking and dining facilities.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector found improvements were required in the oversight of incident management and risks in the centre. Specifically, the review of incidents at meetings between the PPIM and the person in charge did not consider if the required measures were in place to ensure the risk of harm to residents were mitigated. These included areas such as behavioural support and supervision levels for residents following adverse incidents.

There was an incident reporting system in use in the centre, and incidents were documented as they occurred and were then reviewed by the person in charge. Incidents, including safeguarding incidents, were reviewed at monthly meetings with the person in charge and the person participating in management. However, from a review of minutes of meetings it was not consistently evident that incidents were adequately monitored to ensure all required actions were taken. For example, a number of incidents had occurred in July 2022, and were documented as reviewed in August 2022. The person participating in management had not signed off on these incidents records, and there was no reference to the outstanding actions required, which also remained outstanding on the day of inspection. Therefore the inspector was not assured that the process for oversight of incidents in the centre was addressing risks in a timely manner.

Notwithstanding these issues, a number of risks had been identified in the centre, and in most cases there were satisfactory control measures implemented to mitigate the risk of harm to residents, visitors and staff.

Each of the residents had been a missing person profile, which guided practice in the event a resident went missing from the centre. As mentioned, risk assessments incorporated personal plans and the inspector found this arrangement was satisfactory given the remit of the provider as a respite service to provide care and support to residents attending this centre for short stays. Risk management plans included areas such as choking, road safety, infection control, and specific health conditions, and control measures were in place on the day of inspection. For example, recommendations from a speech and language therapist regarding residents feeding eating, drinking and swallowing requirements were available in personal plans.

Judgment: Not compliant

Regulation 27: Protection against infection

The arrangements in place for the prevention and control of infection required improvement, specifically related to laundry management and upkeep of some aspects of the premises. Since the last inspection, the provided had replaced some seating in the centre, and the coverings on all seating was observed to be intact on the day of inspection.

Damage was observed to two kitchen presses and one ensuite door which was not conducive to effective IPC cleaning. The laundry baskets provided for residents' individual use had open perforations, and in the event of an infection control outbreak, would not provide adequate protection against the potential transmission of infection.

The inspector was shown around the centre by a staff member, and overall the centre was clean. Two residents had been discharged on the morning of the inspection, and a deep clean of bedrooms and the bathroom had been completed. There was some damage to the tiled walls in the bathroom; however, this issue was in the process of being rectified.

There were satisfactory arrangements in place for hand hygiene, and staff were observed to wear face masks in line with public health guidance. There were sufficient supplies of personal protective equipment (PPE) in the centre. Satisfactory arrangements were in place for the management of waste in the centre, and for the disposal of clinical waste. The provider had recently completed an IPC audit, and a significant numbers of actions had been developed following this audit. The inspector reviewed 17 of these actions which were due to be completed by the day of inspection; however eight of these actions were not completed. This is further discussed in Reg 23.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed documentation for five residents related to their assessments of need and personal plans. Each resident had an assessment of need completed which was in the main informed by information received from families, staff knowledge of residents, and reviews by multidisciplinary team members. Most assessments of need were up-to-date, and assessments of need documentation were reviewed prior to each resident coming to stay in the centre.

However, up-to-date information was not available from an appropriate professional related to some residents' healthcare needs. Notwithstanding this, the inspector spoke to a nurse on duty and was assured that staff had the required knowledge to

meet the healthcare needs of residents, during their stay in the centre. Personal plans were presented as risk assessments, and the control measures outlined the interventions to ensure residents' needs were met.

Overall personal plans were up-to-date and regularly reviewed to ensure relevance; however, some improvement was required to ensure some interventions in use in the centre had a corresponding personal plans in place, in order to guide practice.

Residents were supported to develop three to four social goals for their stay in respite, and records were maintained once these goals were implemented. Examples of goals included bus trips, meals out, bowling, and walks in nearby parks.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

While some residents were well supported with their behavioural and emotional needs, improvement was required to ensure residents had access to timely behavioural support, specific related to behaviours of concern which occurred only in the respite centre.

The inspector reviewed three behaviour support plans which set out the proactive and reactive supports to help residents manage their behaviours. However, some emerging risks related to behaviours of concern occurring in the centre, did not form part of a behaviour support plan. While these concerns had been identified a number of months ago, and support from a behaviour support specialist was to be sought in July 2022 following an adverse incident, this had not been provided to date. As a result there was no guidance available on how to manage this risk, to ensure the resident's wellbeing was maintained. In addition, a staff member had not received training in managing behaviours that challenge.

In response to the non-compliance from the previous inspection in December 2021, the provider had engaged the services of a behaviour support specialist; however, the person in charge informed the inspector these services were no longer available in the centre.

Judgment: Not compliant

Regulation 8: Protection

Residents were protected by policies and practices in the centre. Staff had been provided with training in safeguarding; however, some staff required refresher training. There had been a number of safeguarding incidents reported to the HIQA since the last inspection. The inspector reviewed documentation pertaining to these

incidents, and found all incidents had been appropriately reported to the relevant authorities. Safeguarding plans had been developed and the measures outlined in plans were implemented in practice. For example, following some peer to peer incidents, the compatibility of some residents had been assessed.

From a review of the directory of residents, the decision to ensure some residents did not avail of respite at the same time had been implemented. The compatibility of residents was also discussed at each staff meeting, and the upcoming respite planner was reviewed by all staff to ensure risks were identified and alternative respite stays offered to mitigate known compatibility concerns. The inspector spoke to a two staff members who described this process, and one of these staff also outlined the procedures to be followed in the event of a suspected safeguarding incident.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Steadfast House Respite Service OSV-0001632

Inspection ID: MON-0038049

Date of inspection: 30/09/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: In order to meet compliance with regulation 14 : Person in Charge • An additional Clinical Nurse Manager 1 has been appointed to support the Person in Charge • The roster will be reviewed by the Person In Charge on a weekly basis and additional staff will be provided to support residents on a needs assessment basis. • In addition 2 staff members have been identified and will be on a on call panel if needs arise.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to meet compliance with regulation 15 : Staffing • An additional Clinical Nurse Manager 1 has been appointed to support the Person in Charge • The roster will be reviewed by the Person In Charge on a weekly basis and additional staff will be provided to support residents on a needs assessment basis. • The registered provider has reviewed the current rota and sufficient staffing levels are available to support residents needs	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In order to meet compliance with Regulation 16: Training and Staff Development • Training matrix is now in place and all mandatory training has been completed by staff • The Person in Charge will review the training matrix every 6 months to identify any	

deficits
• All staff will complete Behavior Support training by the 18-11-2022
• All staff have complete Manual Handling training on the 24-10-2022
• All staff have completed CPR training on the 11-11-2022

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 meet compliance with Regulation 23 Governance and Management

• An Additional Clinical Nurse Manager 1 has been appointed to support the Person in Charge

• The roster will be reviewed by the Person in Charge on a weekly basis and additional staff will be provided to support residents on a needs assessment basis

• The risk management framework policy has been reviewed to include the roles and responsibilities and appropriate pathways in reporting incidents

• Steadfast House Disability Services Operational Manager (previously CEO) will meet with the Board of Directors every month to discuss regulatory compliance monitoring and operational service delivery. The fixed agenda will include incident management, safeguarding, staffing and budgetary issues.

• The Person in Charge will complete the Judgement Framework on a quarterly basis and the actions identified will form part of the Quality Improvement plan for the respite service.

• The Registered Provide will carry out a six monthly unannounced audit and an Annual review of the quality and Safety of care and support and all actions identified will form part of the Quality Improvement plan
• Micom Fire Solutions to conduct full review of fire safety requirements at Steadfast House Respite service.
• A Fire safety audit tool/Checklist will be developed to ensure compliance with regulation 28
• A full review of the centre's incidents will be undertaken by the Registered Provider and the Person in Charge to ensure all incident forms are completed.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In order to meet compliance with Regulation 31:Notification of incident

• The automatic gates have now been added to the restrictive practice log and will be included in the quarterly notifications to HIQA

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to meet compliance with Regulation17: Premises

A full audit of the respite facility took place 03/11/22. Plans have been sent to the board of management for approval and to upgrade the premises as per previous schedule.

€5,000 has been set aside (awaiting quotes as per financial regulations) to address deficits identified by HIQA and will be completed by end of December 2022.

Upgrade in kitchen appliances and units to be completed by end of January 2023.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to meet compliance with Regulation26: Risk Management Procedures

• The risk management framework policy has been reviewed to include the roles and responsibilities and appropriate pathways in reporting incidents

• A clinical nurse specialist is reviewing and updating residents' positive behaviour support plans on 18/11/22 and will monitor on a quarterly basis

• Steadfast House Disability Services Operational Manager (previously CEO) will meet with the Board of Directors every month to discuss regulatory compliance monitoring and operational service delivery. The fixed agenda will include incident management, safeguarding, staffing and budgetary issues

• A full review of the centre's incidents will be undertaken by the Registered Provider and the Person in Charge to ensure all incident forms are completed

• The Person in Charge and the Registered Provider will ensure, under the new risk management policy, that incidents and risks are monitored and any processes that need to be put in place will be put in place in a timely manner

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 meet compliance with Regulation 27: Protection against infection

• The premises will be painted by the end of January 2023
• The kitchen doors presses and the en-suite door will be replace by the end of January 2023
• New Laundry baskets have been purchases for the service users.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
In order to meet compliance with Regulation 5: Individual assessment and Personal plans
• All Residents Healthcare needs and plans will be up dated prior to admission to the Services

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 meet compliance with Regulation 7: Positive behavioural support. • Positive behavioural support training was provided to all staff by the Senior Clinical Psychologists and the Clinical Nurse specialists on the 12-10-2022 • The Clinical Nurse Specialist has reviewed all Positive behavior support plans and is meeting with Management on the 18-11-2022	

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 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.	Not Compliant	Orange	01/10/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/10/2022
Regulation	The person in	Not Compliant	Orange	18/11/2022

16(1)(a)	charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	15/01/2023
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	01/10/2022
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	01/10/2022
Regulation	The registered	Not Compliant	Orange	15/01/2023

23(1)(d)	provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	15/01/2023
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	Not Compliant	Orange	01/10/2022

	emergencies.			
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	07/01/2023
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 occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	15/01/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional,	Substantially Compliant	Yellow	01/10/2022

	of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(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).	Substantially Compliant	Yellow	01/10/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	17/11/2022
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	Not Compliant	Orange	12/10/2022

	techniques.			