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:	Abode Doorway to Life CLG
Name of provider:	Abode Doorway to Life CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	07 September 2021
Centre ID:	OSV-0002411
Fieldwork ID:	MON-0032188

About the designated centre

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

The designated centre provides residential and respite services for up to 10 adults with physical and sensory disabilities, on the outskirts of Cork City. The designated centre is a purpose built building, which comprises of residential units and communal areas for residents. The service operates 24 hours a day, 7 days a week all year round. Staff sleep over in the accommodation provided and are on call for emergencies.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 7 September 2021	08:35hrs to 18:20hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

Overall residents were being supported to live as independent a life as possible. At the time of this inspection, there was no person in charge of the centre. Governance and management arrangements needed to be strengthened by appointing a person to this key role, addressing identified training gaps in the staff team, increasing the provider and staff's understanding and awareness of restrictive practices and ensuring that the service provided was safe by accurately assessing risks and ensuring the facilities provided were compliant with the regulation on fire precautions. Additional oversight of residents' individual plans was also required to ensure that they remained accurate and up-to-date.

This was an unannounced inspection. On arrival, the inspector rang the doorbell and was greeted by a staff member and then accompanied around the building by another staff member to access an office from an external door. The inspector was informed that due to the ongoing COVID-19 pandemic, attempts were made to keep the number of people in the designated centre to a minimum. It was explained that as part of this inspection, the inspector would be spending time in the centre and hoped to meet with residents, if they wished. There were six residents in the centre on the day of this inspection, one of whom was at work for the day. The inspector met with four residents. Enhanced infection prevention and control procedures were in place due to the pandemic. The inspector and all staff adhered to these throughout the inspection.

The Health Information and Quality Authority (HIQA) had been informed that the most recent person in charge of the centre had left the role on 30 July 2021. It was confirmed to the inspector that no person in charge had been appointed to the vacancy. The inspector was also informed of other recent changes to staffing in the centre. On review of the planned and actual rosters, there was evidence of a consistent staff team now in place.

The inspector was shown around the centre by a staff member. The centre was part of a purpose built facility in a suburb of Cork city. The centre provides a residential service for a maximum of ten people with physical and sensory disabilities. Within the same building there is a day service, a training service, and some other rooms providing overnight accommodation. The floor plans submitted to HIQA as part of the registration process indicated which rooms and parts of the building made up the designated centre. It was noted that there was one inconsistency and that a therapy room that had previously been included, was no longer part of the centre. The inspector asked that updated floor plans be submitted to HIQA.

When walking around the building it was noted and explained that three different types of supported accommodation services were provided to residents within the designated centre. These were long-term residential, long-term respite and short-term respite services. Overnight accommodation was provided over two floors in the building. The designated centre was located in a split-level building, therefore those

on the first floor could access the outdoors using external doors.

The residents in this centre were very independent in many areas of their lives. Some had jobs or were hoping to return to employment. The level of staff support required by each resident varied with some not requiring any assistance for days at a time, others requiring support with some specific tasks such as personal care, and others who required more support throughout the day.

There was capacity for six long-term residents in the centre. Each of these residents had a bedroom with an ensuite bathroom. Some residents had small refrigerators in their bedrooms and access to tea and coffee-making facilities. The inspector was informed that residents could also have microwaves in their bedrooms if they wished. There was a commercial kitchen on the ground floor that served meals at set times of the day. Residents were not permitted to access this kitchen. The inspector was told by the chief executive that this was for health and safety reasons. This had not been recognised as an environmental restriction or reported as such to HIQA, as is required by the regulations. When asked where residents could prepare meals or snacks if and when they wished, the inspector was informed of an accessible kitchen in the day service adjacent to the designated centre in the same building. When questioning the availability of this to residents of the designated centre, management informed the inspector that a schedule was in place and it was therefore possible to identify when it was not in use by those attending the day service or training centre. Access to the kitchen or food preparation facilities was not mentioned in any complaints in the last two calendar years or raised as an issue at a resident meeting in 2021.

The inspector met with one of the long-term residents as they were getting ready for the day ahead. They were in the company of two staff who were preparing to support them with personal care. This resident's bedroom was decorated in line with their personal tastes and preferences and they spoke with the inspector about where they had got various decorations. The resident spoke to the inspector about their love of shopping and jewellery, and a planned trip to Cork city the following day. They also spoke about how thankful they were to a relative who had arranged access to a subscription streaming service on the television in their bedroom. They said to the inspector that watching the television was their favourite thing to do. Prior to that, the inspector had briefly met with two of the other long-term residents in the dining area. Another person, who lived in the building but not the designated centre, was also in the room at the time. Both residents were preparing to go out and had made plans as to how they would spend their day.

On the first floor, there were two living areas identified as providing a long-term respite service. On the day of inspection one of these was occupied, while the resident who usually stayed in the other was away on holiday. These areas were described as studio apartments and comprised of an accessible kitchen, dining and living area, a bedroom, and bathroom. While speaking with the current resident of one of the studios, it was clear that they were very independent and did not often need, or request, staff support. The resident told the inspector that in the approximately 13 weeks that they had been in the centre they had requested support from staff on two occasions. The resident was very positive about their

experiences in the centre to date and appreciated the opportunity to return to their native city. This enabled them to see and spend time with family and friends who also provided some day-to-day supports such as lifts to appointments. They told the inspector that they regularly received visitors, spent time in the local community, including the nearby supermarket, and loved to be able to cook their own meals. It was identified in speaking with this resident that they received some multidisciplinary supports, such as occupational therapy, from the Health Service Executive. This arrangement was different to the one described in the Residents' Guide. The inspector was informed that those arrangements related to long-term residents of the centre. While in the studio, the inspector was unsure if the door into the open plan kitchen area was sufficient as a containment measure should it be required in the event of fire. The inspector asked that a competent person review and assess this to provide assurance of compliance with Regulation 28 Fire precautions.

The third type of service, short-term respite, was provided in two other bedrooms. This service was initially stopped and then provided at a reduced capacity during the COVID-19 pandemic. Neither room was occupied at the time of this inspection although one had been used in recent weeks. One of these bedrooms had been identified for use as an isolation unit, should it be required by any of the residents during the pandemic.

There was a communal area on each floor of the designated centre. The dining room was on the ground floor and there was a common area in the landing area on the first floor. The common area had recently been equipped with a computer and notes from a residents' meeting reviewed by the inspector indicated that this addition was welcomed. Staff told the inspector that some social events, including karaoke and a movie night, were held in this area.

Residents' meetings were held monthly in the centre. A variety of topics were discussed. These meetings were used to update residents on staffing changes, upcoming events and activities, and other relevant topics such as the complaints process and public health guidance. Each resident's satisfaction with the service was recorded at a specific point each year and documented in their file. Of the sample reviewed, residents reported feeling secure, that things were working well, that all of their needs were being met, and feeling very happy in the centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

Overall, some good management practices were seen however there was room for improvement. There was no person in charge. Aside from this there was evidence

that the provider had adequately resourced and staffed the service. Management systems ensured that all audits and reviews as required by the regulations were being conducted. However, improvement was required to ensure that these reviews were effective in improving the quality of the service.

The regulations state that the registered provider is required to appoint a person in charge of the centre. The chief executive had informed HIQA when the previous person in charge had handed in their notice and in the interim had attempted to recruit a replacement. One staff member was encouraged to apply for the role but declined. At the time of this inspection, recruitment was ongoing. Despite the absence of a person in this key role there were clear lines of accountability in the centre. Direct support staff reported to a clinical nurse manager, who reported to the chief executive, who reported to the board.

As well as the person in charge, another staff member who fulfilled the roles of complaints officer and designated officer had also recently left the service. A new complaints officer had been appointed and two staff were awaiting training to fulfil the role of designated officer. On review of the complaints log, it was identified that no complaints had been made to date in 2021. Of the six recorded in 2020, it was noted that all had been resolved. However, it was not always noted if this was to the satisfaction of the complainant. Any recent safeguarding issues had been addressed in line with national policy.

The regulations require that an annual review and six-monthly visit reports are completed regarding the safety and quality of care and support provided in the centre. These had been completed and were reviewed by the inspector.

The annual review included a quality improvement plan and there was evidence that these actions were completed or were progressing. It also involved consultation with residents and made reference to 22 questionnaires completed. There was positive feedback in relation to the attitude and support provided by staff in general and also specifically during the pandemic. The premises was also praised, as was the food provided. Residents also reported feeling safe. Feedback also referenced areas of resident dissatisfaction. Examples included resident's privacy, staff moving resident's belongings, and one resident reporting that they had been supported to get into bed at 8pm which they felt was too early. The author of the annual review concluded that the need for increased flexibility continued to be a recurring theme. However there was no action in the improvement plan to address this identified, recurrent issue.

The inspector reviewed the three most recent six-monthly visit reports. These involved a person nominated by the registered provider visiting the centre (when this was in line with Public Health advice), speaking with a selection of staff and residents, and some documentation review. The six-monthly visit reports were not comprehensive and did not review many aspects of care and support specified in the regulations. No concerns were identified in any of the three visits and as a result no action plans were generated. Management informed the inspector that there had been a recent discussion regarding adopting a different report format which would

be more detailed in nature and aligned with the regulations.

All three six-monthly visit reports stated that there were no restrictive procedures in use in the centre. This was not consistent with the quarterly notifications submitted to HIQA which reported restraints used. As outlined earlier in this report, the fact that residents were not able to access the kitchen in the designated centre was neither recognised nor reported as a restriction. Later in the inspection, the use of a monitoring device for one resident was brought to the inspector's attention. The use of this had also not been reported to HIQA, as is required by the regulations. The inspector concluded that management required greater awareness and understanding in the area of restrictive practices.

The inspector reviewed the training matrix available for thirteen staff working in the centre. It became evident as the inspection continued that this matrix was not up to date. The inspector also reviewed a selection of available training records for individual staff. A member of the team had recently completed a course to train their peers in medication management and there was evidence of a training session completed in the month prior to this inspection. It was identified that two staff required training in fire safety and the safe administration of medication, and ten staff required training in both the management of behaviour that is challenging and epilepsy management. The inspector saw records of correspondence regarding arranging epilepsy training. The chief executive informed the inspector that none of the current residents or potential short-term respite residents were prescribed emergency medication for the treatment of epilepsy.

Regulation 14: Persons in charge

There was no person in charge appointed in this centre.

Judgment: Not compliant

Regulation 15: Staffing

The planned and actual staff rota was well maintained. Despite recent changes, a consistent staff team was in place at the time of the inspection. Personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

A number of staff required mandatory training. Training was required in fire safety, the safe administration of medication, the management of behaviour that is challenging and epilepsy management. While evidence was seen of efforts to arrange staff training sessions, no dates were confirmed at the time of this inspection. Management informed the inspector that no current or prospective respite resident was prescribed emergency medication to treat epilepsy.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a directory of residents in the centre that was well maintained.

Judgment: Compliant

Regulation 23: Governance and management

Improvement was required to the management systems in place to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Not all areas identified as requiring improvement in the annual review had generated a corresponding action. The six-monthly visit reports were consistently inaccurate regarding some of the supports provided in the centre. This was indicative of a broader low level of understanding of restrictive practices in the centre. Additional oversight of residents' individual plans and risk assessments was also required to ensure that they remained accurate and up-to-date.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Prospective residents had the opportunity to visit the centre prior to moving in. Written agreements were in place outlining the terms of residence in the centre. These agreements also outlined the fees to be charged, if any.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that it accurately reflected the services provided, the management structure in place, and which parts of the building were and were not part of the designated centre. The centre's policy and procedure for emergency admissions and the number, age range and gender of the residents in the centre also needed to be included.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all occasions where restrictive procedures were used in the centre were reported to HIQA.

Judgment: Not compliant

Regulation 32: Notification of periods when the person in charge is absent

The absence of the person in charge was reported to the chief inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

It was not always documented if residents were satisfied with the outcome of complaints made.

Judgment: Substantially compliant

Quality and safety

The inspector found that the quality and safety of care provided was of a good standard. A review of documentation and the inspector's observations indicated that residents enjoyed living in this centre. Residents' independence was clearly very important to them and there was evidence that this was respected and encouraged. Areas identified as requiring improvement included review and maintenance of residents' plans, accurate assessment of risk, and ensuring that containment measures in the centre were adequate with regards to the requirements of the fire

safety regulation.

The inspector reviewed a sample of residents' files and personal plans. These had all been recently reviewed. Despite this, some of the documents included in the files were not accurate, were incomplete or were not signed. For example, weekly schedules outlined activities that have not taken place since the beginning of the COVID-19 pandemic in March 2020. There were multi-disciplinary reviews of residents' plans however in some cases, although invited, the multidisciplinary staff involved in their care and support did not attend the review meeting. In these cases, their input was not sought or documented in another way. In each plan reviewed, it was documented where residents wished to independently manage aspects of their own care, for example arranging their own medical appointments. Where staff support was required, each resident had a personal and intimate care plan.

Recently completed health and medical assessments were in place for residents. The plan structure indicated that for each assessed need there would be a corresponding healthcare plan, however this was not always the case. For example, one resident was assessed as being at very high risk of developing a pressure sore. However there was no documented plan for staff or the resident regarding this. In other healthcare plans, the guidance for staff was vague and the effectiveness of the plans had not been assessed. Despite these documentation issues, there was evidence that residents' healthcare needs were well met. There was also evidence that residents were supported to access medical professionals as required, with evidence of treatment received from public health nurses, allied health professionals, general practitioners (GPs) and specialist consultants.

The inspector also reviewed a sample of individual risk assessments. The ratings required review to ensure that they were reflective of the risk posed by the identified hazard. For example, the rating of the impact posed by a certain hazard was not always accurate. In other assessments, the control measures implemented by the provider were not reflected in the risk rating. The management team advised the inspector that a review of the risk register was underway.

Personal plans had also been developed documenting goals residents wished to achieve. Often these goals highlighted residents' wishes to further their independence, for example by learning to drive. Other goals involved going to shops, returning to usual day service hours, spending time with relatives and other activities that were negatively impacted by the COVID-19 pandemic. Although it was stated that goals would be reviewed every three months, this was not the case in all of the plans. Some plans did not document how or by when goals would be achieved.

Of the six long-term residents, one had a full-time job and the other five either attended a day service, employed a personal assistant (PA), or did a combination of both. All those attending a day service had experienced a reduction in the time they spent there due to the COVID-19 pandemic. When community access was restricted, the day services manager who worked in the same building facilitated additional activities for all residents in the centre. These included a race night, karaoke, themed parties, quiz nights and the Jerusalem dance challenge. One resident had

chosen not to return to their day service while others were hoping for a return to their regular hours. Two residents who had been attending four and five days a week respectively, had recently resumed attending one day a week.

Maintaining family contact and other significant relationships was very important to the residents of the centre. Many did this independently and privately. Visits to family homes had also stopped during the pandemic, however these had since resumed. At the time of this inspection, one long-term resident and one long-term respite resident were staying with relatives. Visitors were welcomed to the centre as soon as public health guidelines indicated that it was safe to do so. To ensure resident and staff safety, a room with direct external access was made available and equipped with specialist cleaning equipment. A visiting protocol including taking temperatures and use of personal protective equipment was adhered to.

A COVID-19 contingency plan and a centre-specific protocol were in place. These had been subject to regular review. An infection prevention and control self-assessment had also been completed. A folder including the most up-to-date Health Service Executive (HSE) information was also available for staff information and review. From the outset of this inspection it was demonstrated that staff were very aware of, and implementing, all documented precautions.

Regulation 11: Visits

Residents were free to receive visitors if they wished. Due to the ongoing COVID-19 pandemic, there were specific guidelines in place to facilitate visitors to the centre.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access to facilities for occupation and recreation. During the pandemic, the provider enhanced the opportunities they provided to residents within the centre. Outside of this many residents organised their recreational activities independently, at times with the support of Personal Assistants or friends and family. At the time of this inspection many residents were hoping to return to pre-pandemic levels of attendance at day services. There was evidence that staff were supporting them to achieve these goals.

Judgment: Compliant

Regulation 17: Premises

The premises were designed and laid out to meet the needs of residents. They were clean and bright and equipped with the aids and appliances residents required. Accessible kitchens were provided to two of the residents in the designated centre.

Judgment: Compliant

Regulation 20: Information for residents

The residents' guide required review. It did not detail what fees, if any, must be paid while staying the centre. The procedure respecting complaints also required more detail. As was identified during this inspection, access arrangements to some allied health professionals varied among the different types of service provided. This should be clearly documented.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

At the time of this inspection, preparatory work was underway regarding the future discharge of a resident from this service. The resident was actively involved in the discussions and planning relating to this.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk assessments required review to ensure they were reflective of the current hazards and the risks they posed.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

This regulation was not inspected in full. The inspector requested assurance from a competent person that the containment measures in the centre met the requirements of this regulation.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment that resulted in the development of a personal plan. Although annual multidisciplinary review meetings were arranged, there was not always evidence of multidisciplinary input in the review of resident's personal plans. It was also identified that the effectiveness of some healthcare plans was not assessed. Residents had developed plans outlining their personal development goals. Not all of these had been reviewed within the timelines specified.

Judgment: Substantially compliant

Regulation 6: Health care

Appropriate healthcare was provided to residents in line with their personal plans.

Judgment: Compliant

Regulation 8: Protection

There were no safeguarding concerns in the centre at the time of this inspection. Previous concerns had been addressed in line with national policy. Of the sample reviewed, all residents had an intimate and personal care plan in place that considered their dignity and areas of independence. All staff had received training in relation to safeguarding residents and the prevention, detection, and response to abuse.

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 - 2015 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Abode Doorway to Life CLG OSV-0002411

Inspection ID: MON-0032188

Date of inspection: 07/09/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Person in Charge has been appointed to the post and all relevant documentation has been submitted to HIQA as per regulations.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff Training has been scheduled to address the training needs as follows. • Epilepsy/Buccal Midazolam Training- 28/10/2021 • Management of Behavior that is Challenging- 23/11/2021 • Fire Training- 23/11/2021 • Heart saver CPR/AED completed by staff on 30/09/2021 • Responsible and Safe Medication Management 2-day training completed by staff in the designated centre on 18th & 19th August 2021. A review system has been developed to ensure Training Matrix remains up to date. One individual administrative staff member has been identified to ensure the maintenance of the matrix.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The 6 monthly reports will be completed in accordance with regulation 23 on template provided and relevant action plans will be generated accordingly.
All Designated Centre staff and management will sign off that they have read and understood HIQA Guidance for Designated Centre Restraint Procedures (April 2016).
A Restrictive Practice log will be drawn up to identify and describe any/all restrictive practices within the Centre. The restrictions within the log will be reviewed quarterly or as required with the PIC and residents within the Centre. The restrictive practice log will be drawn up and implemented by the 31st of January 2022.

Management will source a training course to provide additional education, knowledge, understanding and awareness of Restrictive Practices.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of Purpose will be updated to reflect:
• Changes in the Management structure in the Designated Centre.
• Clearly defined parts of the designated Centre.
• Policy and Procedure for emergency admissions.
• The number, age range and gender of the residents.
Floor plans were revised on 13/10/2021 to reflect changes to the designated Centre and have been submitted to HIQA office on 19/10/2021.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
One of the restrictive practices highlighted in the HIQA report was installed on 02/07/2021 and will be notified to HIQA in the third quarter returns in line with regulatory requirements. This restriction has now ceased.
The other environmental restriction identified in the report will be discussed in

collaboration with the residents at the next scheduled residents meeting.
All identified restrictions will be notified to HIQA at the end of each quarter of the calendar year in line with HIQA regulations.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints document has now been revised to include a section addressing the person's satisfaction with the outcome of their complaint.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
Resident's guide will be updated to include.
• Fees payable in line with Residential Support Services Maintenance and Accommodation Contribution (RSSMAC).
• A more detailed section addressing Abode's complaint procedure.
• Information on access arrangements to Allied Health Professionals for residents in the designated Centre i.e., long term stay and/or long-term respite stay.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk Assessment Refresher training will be provided for designated Centre staff to ensure that current and future assessments are robust, and the rating reflects existing controls in place.
Risk assessments will be reviewed six monthly or as required.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A review of fire precautions across the designated Centre has been scheduled for 23/11/2021. This will include assessment of interior apartment/ studio doors. A report on the findings will be submitted to HIQA.	
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: A robust review of Person-Centered Plans/goals, Healthcare action plans, activity/daily timetables etc. will be scheduled for monthly review with both keyworker and resident and reviewed quarterly with keyworker and PIC. The effectiveness of health care plans will be reviewed and documented during the monthly meetings. The actions/outcomes from reviews and any changes made will be recorded and updated in documentation within the individual's PCP. MDT input will be recorded and updated as and when interventions occur. Members of the MDT will be requested to submit a report post individual assessments and in the absence of individual annual reviews.	

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(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	07/10/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/11/2021
Regulation 20(2)(b)	The guide prepared under paragraph (1) shall include the terms and conditions relating to residency.	Substantially Compliant	Yellow	31/12/2021
Regulation 20(2)(e)	The guide prepared under paragraph (1) shall include the procedure respecting complaints.	Substantially Compliant	Yellow	31/12/2021
Regulation	The registered	Substantially	Yellow	31/01/2022

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.	Compliant		
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.	Substantially Compliant	Yellow	31/03/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/11/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/11/2021
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	Not Compliant	Orange	31/10/2021

	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.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	21/10/2021
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	31/03/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out	Substantially Compliant	Yellow	31/03/2022

	annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	31/03/2022