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:	Graifin House
Name of provider:	The Rehab Group
Address of centre:	Dublin 18
Type of inspection:	Unannounced
Date of inspection:	28 June 2022
Centre ID:	OSV-0002636
Fieldwork ID:	MON-0032656

About the designated centre

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

This community based residential centre provides a high support residential service for adults with Prader-Willi Syndrome (PWS). Each individual has complex health and social care needs. The house is a two-storey, six bed roomed building located on a main road in a suburban area in Co. Dublin. Residents access the building from a side entrance. A large garden area is available to the front and side of the premises. Each resident has their own single room with one located on the ground floor and four on the second floor. The house is close to a broad range of services and amenities, with a public transport system also locally available. There is capacity for five residents and they are supported over the 24 hour period by care support workers, team leaders and the person in charge.

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
Tuesday 28 June 2022	09:45hrs to 17:00hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This unannounced inspection took place to monitor regulatory compliance following the receipt of a high number of notifications of alleged psychological abuse in the centre. From what the residents told us and what the inspector observed, it was evident that residents were engaging in activities they enjoyed and were consulted with in relation to their care and support. They were receiving specialist health and social care specific to their diagnosis. However, the inspector found that there were ineffective safeguarding arrangements in place in the centre to protect residents from ongoing psychological abuse. The inspector also found that in some cases, residents' rights to privacy , safety and retaining control of their finances were compromised.

The centre is a six-bedroomed house which is located on a busy road in a suburban area. Downstairs comprises a kitchen, dining room, living room, office, gym, toilet and a bedroom with an en suite bathroom. There is a split staircase and on one side there are three bedrooms, an office and a bathroom and on the other side a further three bedrooms, one of which is used as staff sleepover room and a bathroom. There is a garden area to the rear of the house which has a garden room available for residents to use. The premises was found to be unsuitable for residents who had bedrooms upstairs due to changing mobility and health care needs. One of the residents told the inspector that they required a new shower as the shower in place was becoming difficult for them to manage. This had been a finding on previous inspections and the provider had a long-term plan in place to re-develop the site to provide ground-floor accommodation for residents.

There were two residents present in the centre on the day of the inspection. One resident was in hospital and another was staying with their family. The two residents in the centre were restricting their movements due to a suspected case of COVID-19 and therefore, the inspector engaged with them briefly and at a two metre distance and wearing appropriate personal and protective equipment (PPE). One of the residents told the inspector about their new day service and they were caring for their pet that day. They spoke about a club they attended which had now returned to meeting in person. They spoke of their wish to live independently and reported to the inspector that the provider and management team were working on it for them.The second resident greeted the inspector and told them they were staying in the house for the day. They were listening to music. Residents had a number of trophies on display from sporting events they had done in bocce and table tennis. There were photographs of family in the living area and their personal belongings were on display. Each resident had their own room and access to a gym room which they used daily as part of their health-care support plan.

Residents in the centre had complex health and social care needs due to their diagnosis. They received specialist support which included services from allied health and social care professionals such as a Clinical Dietitian and a behaviour support therapist. The inspector reviewed residents' notes and saw that residents who

wished to attend day services were facilitated to do so. Other activities residents enjoyed within the house were watching television, playing games on personal tablets, caring for their pet, typing, going shopping and using local amenities such as hairdressers. For one resident, staff were working on expanding the activities they had done prior to the government restrictions while being respectful of the resident's right to choose their daily activities.

The inspector found that there were longstanding compatibility issues between residents in the centre, resulting in a high number of notifications of alleged psychological abuse submitted to the Authority. These incidents had increased in recent months. The provider had a long -term plan in place to secure an individual home for one resident and re-develop the site for the other residents. However, the interim safeguarding arrangements in place were not effective in preventing or reducing these incidents. These incidents had been occurring for some time and due to the sustained nature of these incidents, this was having a negative impact on residents' quality of life. Residents had made a number of complaints in relation to their living situation to the provider.

For some residents' , it was found that their right to retain control over their finances was compromised. A review of residents' plans indicated that two of the residents did not have direct access to their bank account and these accounts were managed by family members. The provider had a local procedure in place to ensure residents' finances were safeguarded for these residents. However, for other residents, there was evidence that their right to independence and developing skills in managing their finances and budgeting was promoted. The inspector found that some residents were checked on an hourly basis each night. This was impacting on their right to privacy and it was unclear what decision -making process had been used to put this practice in place.

Overall, the inspector found that residents were well-cared for and that staff were endeavouring to provide a person-centred service in a premises which was not conducive to residents' needs and in a centre where there was ongoing compatibility issues. Residents who the inspector met on the day were well presented and appeared comfortable in the company of staff. The next two sections of the report present the inspection findings in relation to the governance and management in the centre, and how the governance and management arrangements affects the quality and safety of the service being delivered.

Capacity and capability

The provider was found to have good management structures, systems and processes in place to monitor and oversee the quality of care provided to residents. The provider had carried out an annual review and a six monthly unannounced provider visit in line with the regulations. There were a number of quality assurance checks in place, with action plans developed and regularly reviewed. It was evident

that all levels of management were actively involved in trying to source suitable properties and funding to best meet the residents' needs in both the medium and long-term period while works were completed on the site. The estimated date given to the chief inspector for these dates was June 2023.

Day-to-day management of the centre was the responsibility of the person in charge. They were supported by team leaders. The person in charge had a number of systems in place to monitor practices in the centre, to ensure that all relevant information was shared with staff in a timely manner and to action areas as required with staff support. The person in charge attended a meeting with other persons in charge twice a month. Staff meetings took place every three weeks. This was contrary to residents' safeguarding plans which indicated that these meetings would occur on a weekly basis.

The designated centre was resourced with a sufficient number of staff to meet the residents' assessed needs. The provider had defined the ratio of staff required to safely support different numbers of residents in the centre. The maintenance of rosters required improvement to ensure that full names of all staff completing shifts were recorded. Staff training was mostly in date and included mandatory training in safeguarding, manual handling, the management of actual or potential aggression (MAPA) and first aid. However, there were a number of refresher courses outstanding. Further detail is provided under the regulatory judgment below.

A review of incidents notified to the Chief Inspector indicated that three incidents relating to safeguarding had not been notified to the Authority, as required by the regulations.The provider had a complaints policy in place and the procedure was available in the centre. A review of complaints in the centre indicated that residents were supported to voice their concerns and that they were listened to. Some of the complaints viewed by the inspector were not dealt with in line with the provider's policy.

Regulation 15: Staffing

The provider had resourced the centre with sufficient staff in order to meet the residents' assessed needs. There were defined ratios of staff required based on the numbers of residents present in the house. The planned and actual rosters indicated that residents had good continuity of care, with regular relief or agency staff used as required. However, the actual rosters did not contain the full names of agency staff who had completed shifts in the four week period prior to the inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff training records viewed by the inspector indicated that most staff had completed mandatory training in areas such as safeguarding, manual handling, the management of potential or actual aggression and supporting residents' finances. Staff had completed additional training in infection prevention and control, hand hygiene, donning and doffing of personal protective equipment (PPE) and on standard and transmission based precautions. However, there were gaps identified in training. For instance, three staff required an update in medication management, three required an update in fire safety and five staff required first aid training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that there was a clear management and reporting structure in place. The provider had carried out an annual review which included the voice of one resident and one family member. Six monthly unannounced visits were completed in line with regulatory requirements and action plans were developed where required. There were emergency governance arrangements in place. The provider had an online system to store residents' care and support plans. This system had key performance indicators and enabled management to track progress of personal plans and identify any gaps in the documentation which required follow up by key workers. Key workers provided a monthly report to the person in charge.

There were a number of quality assurance audits carried out within the centre on a weekly and monthly basis in areas such as daily notes, IPC practices, action plans and risk management. A sample of minutes from staff meetings were viewed by the inspector and showed that there was a set agenda in place for meetings to ensure all information relevant to residents and to the service itself was shared and discussed with the staff team.

However, the inspector was not assured by the governance and management arrangements in place in relation to safeguarding in the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

On review of notifications in the centre, the inspector noted that while the provider had documented and reported all safeguarding incidents in line with national policy, a small number of notifications had been submitted incorrectly or omitted by the provider to the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a complaints policy and procedure in place and this was made available to residents and their families. Complaints were documented and logged by the person in charge. Residents were supported to make complaints where they expressed concerns to staff members or the person in charge. There were ten complaints made by residents in the eighteen month period prior to this inspection. These complaints related to residents' dissatisfaction with their living arrangements and the incidents which were occurring in the house. The inspector found that complaints documented were not followed up in line with the provider's policy. For example, a complaint made by one resident about their living situation was kept open , as it remained unresolved. However, there were a number of complaints on the same issue from other residents which were documented as being resolved at the point of contact.

Judgment: Substantially compliant

Quality and safety

As stated earlier, it was evident to the inspector that residents were provided with a person-centred service in what was a difficult environment due to the unsuitability of the premises and ongoing safeguarding incidents. Residents were now accessing clubs and day service since government restrictions had lifted and staff reported that this was having a positive impact on residents' quality of life. Interactions between staff and the residents was noted to be respectful and kind. It was evident that the residents present in the house were comfortable in the presence of staff.

The inspector reviewed positive behaviour support plans and found them to be detailed with clear guidance for staff. The restriction in the centre was in place due to residents' care needs and was prescribed and regularly reviewed by the restrictive practice committee. Documentation relating to these restrictions reflected discussions held on the impact of the restriction on residents and what measures were taken to reduce the restriction.

As mentioned earlier in the report, there were a high number of notifications relating to alleged psychological abuse in the centre. In the eighteen months prior to this inspection, 34 notifications relating to peer to peer incidents had been submitted. The inspector found that for the most part these were documented, reported and investigated in line with national policy. However, there was a discrepancy noted between the notifications received by the Authority and incidents reported to the Health Service Executive (HSE), with a higher number of incidents reported to the

HSE. There were safeguarding plans in place. However, the measures taken were proving ineffective in preventing or reducing these incidents. There were medium and long-term plans in place to change the living arrangements for residents. However, the inspector was not assured that there were adequate safeguarding arrangements in place while residents continued to live together.

Residents' rights were for the most part promoted and supported. However, the inspector found that two of the four residents did not have direct access to their bank accounts. Furthermore, there was a practice of checking on residents on an hourly basis each night which was restricting their right to privacy.

There had been an improvement in the state of repair of some areas of the premises since the last inspection. Other areas such as a residents' bedroom had not been completed. As stated earlier, the premises was no longer suitable to meet the needs of residents, with complaints documented that residents found the stairs and the shower difficult to manage. The provider was aware of this and was working on a long-term plan to re-develop the site.

Risk management systems were in place in the designated centre. The inspector found that risks were identified, assessed and managed. Risk assessments were centrally logged and regularly reviewed. Adverse incidents were reported and analysed monthly to identify trends and learning for the centre. This learning was shared with management and staff.

Fire containment systems had been strengthened since the last inspection. The provider had fitted a number of hold-open devices to fire doors downstairs. Appropriate detection systems and emergency lighting were in place. In response to the last inspection, the provider had amended the local procedure for staff to follow in the event of a fire at night-time. Residents' personal emergency evacuation plans had not been updated to reflect this change.

Regulation 17: Premises

The provider had plans to complete urgent works on the property in the weeks following this inspection. However, the premises remained unsuitable for residents' changing mobility and health care needs due to the stairs and a shower being difficult for residents to access. This had been identified on a number of previous inspections. The provider has committed to re-developing the site in order to provide ground-floor accommodation for the residents. This was at planning stage on the day of the inspection.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had systems in place to identify, assess and mitigate risks for residents, staff and visitors to the centre. Risks were clearly documented and assessments were regularly reviewed in line with the provider's time lines. Where adverse events occured, these were documented on the provider's online system and identified learning was shared with staff at team meetings. Oversight of risk and adverse events was maintained through the use of a risk register and a monthly incident analysis report.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had fitted hold-open devices on fire doors since the last inspection. The inspector found that there were suitable systems in place for the detection of fires and that emergency lighting was in good working order. The provider had fire fighting equipment in appropriate areas of the centre. There was documentary evidence of daily, weekly and monthly checks being carried out by staff in addition to checks by an external fire consultant to ensure all equipment in the centre was serviced and maintained. The person in charge had met with residents about drills and the need to evacuate since the last inspection.

The inspector was not adequately assured that safe evacuation of all residents was achievable at night time. On the last inspection, it was found that a resident had locked their door on a night-time drill which required staff to get keys from a kitchen downstairs. Following this inspection, the local evacuation procedures had been updated to reduce this risk by staff having keys available to them upstairs. However, this plan was not contained in the fire folder and the resident's personal emergency evacuation plan was not updated to reflect this change.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that residents who required positive behaviour support plans had comprehensive plans in place. These plans detailed a number of potential situations which may arise and gave staff clear guidance on proactive and reactive strategies to use. Plans were reviewed by the behaviour therapist and staff every six months, as outlined in safeguarding plans. There was evidence of the person in charge engaging with staff to ensure that there was consistency in practices among staff members when involved in a behavioural incident. Restrictive practices were in place due to the complex health-care needs of the residents. The restriction in place was regularly reviewed by the restrictive practice committee. There was evidence of

attempts to reduce these restrictions in a safe way with the residents' consent. There was easy to read information available on the reasons for the restrictive practice in place. For example, the kitchen door was opened to support residents to prepare a meal in the company of staff.

Judgment: Compliant

Regulation 8: Protection

The inspector found that residents continued to be living in an arrangement which was unsuited to their needs and compatibility issues were leading to sustained psychological abuse for some residents. This was having an ongoing negative impact on their quality of life in the centre. There had been 34 notifications of alleged psychological abuse between residents submitted to the Authority in the eighteen months prior to the inspection. On review of preliminary screening forms submitted to the HSE, it was noted that there were five further safeguarding incidents which had been omitted or incorrectly submitted to the Authority in that time frame.

Safeguarding plans were in place and agreed with the HSE. The measures in these plans were proving ineffective as they were not reducing the number of incidents occurring in the centre. While it is acknowledged that there were plans in place for the medium to long -term to change these living arrangements, the safeguarding arrangements in place while residents continued to live together were not satisfactory.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector found evidence that residents were consulted with and participated in a number of aspects of the running of the designated centre, particularly in relation to their care and support plans such as their diets, activities and restrictive practices. The person in charge held a meeting with all of the residents on a monthly basis where they shared information about staffing, maintenance, plans and other house -related issues. However, it was found that some of the residents' rights were compromised in relation to having direct access to bank accounts, their right to privacy and the right to live in a safe environment.

Two of the residents in the centre had direct access to their bank accounts and held their own ATM card. There was evidence to show that work was ongoing with these residents to promote their rights to independence and to develop skills in money management. However, two of residents did not have direct access to their bank

accounts which were managed by family members.

On a review of daily notes of residents, the inspector noted that residents were checked on an hourly basis overnight which impacted on their right to privacy. It was unclear what decision-making process or discussions had taken place in relation to this practice. The provider committed to doing an immediate review of this process on the day of the inspection.

The frequency and intensity of safeguarding incidents were such that they had a significant negative impact on the quality of lives of the residents living in the centre. Residents' complaints indicated their dissatisfaction with the living arrangements which are currently in place.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Graifin House OSV-0002636

Inspection ID: MON-0032656

Date of inspection: 28/06/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Full names of all staff are now included on the rota, this was completed on 05/07/2022.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training records supplied on the date of the inspection had not been updated with all completed training on that date. For example the majority of staff working in the service had completed first aid training (Nov. 2021). The training record has now been updated. This was completed on 05/07/2022. • One staff member requires medication training, this training will be completed by 31/08/2022. This staff member is a period of leave currently. • Fire safety training was completed in the service on 12/07/2022. At present one staff member requires fire safety training, this will be completed by 31/08/2022. • One staff member to complete MAPA training by 31/08/2022. • Two new staff members are currently engaging in all mandatory training this will be completed by 31/08/2022. Measures are in place to ensure continuity of care for residents during this period, this includes management of the rota to ensure that all times fully trained members of staff work alongside new staff members yet to complete their training	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Weekly and Monthly service reviews will continue to be completed to ensure the service is consistently and effectively monitored. These include a review of all incidents and safeguarding reports and actions outstanding from Internal Audits and HIQA Inspections.

• The Provider will continue to complete Six Monthly and Annual reviews of the service as required. The most recent six monthly review was completed on 20/07/2022.

• The Rehab Group Board has been made aware of the findings of this inspection. The service will continue to be identified as a service of concern on the Provider's Monthly Senior Leadership Team and Board Reports and will remain at this level until all issues identified in this report have been resolved.

• Actions from this plan will be added to the Provider's Action Tracking Database and regular updates will be provided by the PIC and PPIM. These updates will be included in monthly reports to the Senior Leadership Team and the Board.

The provider will establish enhanced oversight of this service whereby regular updates (monthly meetings at a minimum) on progress of this Plan and any other service issues as they arise will be monitored and addressed by the PIC, Senior Operational Managers (PPIMs) with support from relevant members of the Quality & Governance Directorate and New Grove Housing Association. This forum will be led by the ISM (PPIM) and will remain in place until all actions identified in this plan have been addressed.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC has completed a review of incidents and notifications in the service. Any outstanding notifications will be submitted retrospectively including one that had been previously submitted but cancelled on the system. This will be completed by 22/07/2022.

• The PIC will implement a tracking system for all safeguarding incidents, this will include cross reference between incident reports, PSFs and NF06s. This will be completed by 15/08/2022.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC will review all closed complaints and re-open those that refer to the ongoing compatibility issues in the service. This will be completed by 15/08/2022.

• These will remain open until the living arrangements are permanently resolved.

• The PIC will provide regular updates to residents in relation progress of plans.

• The Provider's Complaint's Officer will visit the service and introduce themselves to the Residents and advise them of their role and availability to support them with complaints. This will be completed by 14/08/2022.

• Resident's will be reminded of their right to access both internal and external advocacy supports and where they chose to staff will support them to request access to same. This will be completed by 31/08/2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Painting of all internal areas (excluding 3 bedrooms) was completed by 19/07/2022.

• Removal of rusted fittings was due to be completed by 21 /07/2022, however due to COVID this has been delayed and will now be completed by 31/07/2022.

• The Provider is progressing with the purchase of a two bed apartment in South Dublin. The Resident who has expressed a wish to live alone will be supported to transition to live in the service.

• At present the Provider is liaising with New Grove Housing Association, the Provider's Property Department and the Local Housing Authority with a view to resolving issues relating to the suitability of the premises.

• The provider has a long term plan to address the environment issues, the specific details of this plan will be provided to the regulator as part of the response to the meeting held on 15/07/2022, this will be provided by 15/08/2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PEEP for one Resident has been updated to reflect the use of keys at night time in line with guidance in the local evacuation plan. This was completed on 05/07/2022.

• A copy of the local evacuation plan was placed in the fire fact file on 05/07/2022.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• As identified above the Provider is currently working to address the issues relating to the current living situation in the service on a permanent basis this will resolve the safeguarding issues in the long term. The Provider is committed to supplying specific details of this plan to HIQA by 15/08/2022.

• In the meantime locally a number of measures continue to be implemented, these measures include:

One to one ratio for some community activities
Residents are supported to engage in activities separately

Ongoing behaviour therapist input and implementation of behaviour support plans.
Resident has been supported to return day service.
Resident has chosen to finish with Psychology Support but is aware that this support is available should the resident wish to re-engage with these supports.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• PIC will make contact with the GP of one resident who uses an apnoea machine to determine the need for hourly night time checks, based on GP feedback and on consultation with the resident practice will be adapted accordingly. This will be completed by 31/07/2022.

• With regard to other residents they will be consulted in terms of preference for night time checks and practice will be updated accordingly. This will be completed by 31/07/2022.

• The two Residents who do not have direct access to their bank accounts have been consulted and have chosen for their families to support them with all aspects of their financial affairs. This is reviewed with the resident on annual basis during circle of support meetings and to date they have indicated they are happy with this arrangement. Documentary evidence of same is available in the service.

• Once the Assisted Decision Making Act is enacted and support is available through the Decision Support Service Residents will be reminded of its availability and supported to access same should they choose to do so.

• As identified above the Provider is currently working to address the issues relating to the living situation in the service on a permanent basis. The Provider is committed to supplying specific details of this plan to HIQA by 15/08/2022.

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 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	05/07/2022
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	31/08/2022
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	Not Compliant	Red	30/06/2023

	number and needs of residents.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Red	30/06/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Red	31/07/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable,	Substantially Compliant	Yellow	05/07/2022

	residents, are aware of the procedure to be followed in the case of fire.			
Regulation 31(1)(a)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.	Not Compliant	Orange	15/08/2022
Regulation 34(2)(a)	The registered provider shall ensure that a person who is not involved in the matters the subject of complaint is nominated to deal with complaints by or on behalf of residents.	Not Compliant	Yellow	14/09/2022
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	30/06/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of	Not Compliant	Red	31/07/2022

	abuse.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Red	31/07/2022