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:	Lifford Accommodation
Name of provider:	The Rehab Group
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	10 November 2022
Centre ID:	OSV-0002678
Fieldwork ID:	MON-0038192

About the designated centre

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

Lifford Accommodation provides full-time residential care and support for up to eight adults (male and female) with a disability. The designated centre comprises of two interconnected semi-detached houses. Residents in each house have their own bedrooms and also have access to shared bathroom facilities on both the ground and first floors. In addition, the house includes a communal sitting room, kitchen dining room and laundry room for residents' use. The centre is located in a residential housing estate in a town and is close to local amenities such as shops, cinema and cafes. Residents are supported by a team of support workers, with staffing arrangements in each house being based on residents' assessed needs. In addition, management support is available to staff outside of office hours through the provider's on call system if required. Residents can access a number of amenities in the local community including an equine centre, cinema, community garden and shops.

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 (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
Thursday 10 November 2022	10:25hrs to 17:10hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This was an unannounced inspection of the centre following receipt of information by the Health Information and Quality Authority (HIQA). Overall, the inspector noted that the provider had taken proactive steps to identify service improvement issues in the centre. The provider had also introduced new governance arrangements in response to the findings from audits and internal reviews. However, throughout the inspection, it emerged that the provider repeatedly failed to devise specific and timeframed plans to address issues identified. Though broad areas for service improvement were identifed, the absence of a comprehensive service improvement plan meant that the provider could not ensure that issues were addressed in a timely and satisfactory manner. This will be outlined in the report.

The centre consisted of two interconnected semi-detached houses located on the edge of a town. The houses were two-storey and linked by an internal door between the two kitchens. The inspector visited both houses and viewed the communal rooms that were used by all residents. Both houses had a kitchen-dining room with seating area. There was also a separate living room in each house. Residents had their own bedrooms. In each house, one bedroom was located downstairs and the rest were located upstairs. Each house had a bathroom downstairs with a level access shower. The bathrooms upstairs had full baths with showers overhead. Outside, the residents had access to a small front and back garden.

The inspector noted that there were areas within the house that required refurbishment. For example, grouting was missing from the tiles around the sink in one kitchen. There was damage due to wear and tear on the edges of kitchen cabinets. Grouting in bathrooms was discoloured in places and attachments for soap dishes, etc. were rusted and damaged. The person in charge and a member of management within the centre reported that there were extensive refurbishments planned for the centre. These refurbishment works formed part of the safeguarding plans that were open in the centre. However, there were no definite dates or a comprehensive plan regarding these works. This will be discussed later in the report.

The inspector had the opportunity to meet with five of the six residents on the day of inspection. One resident was out of the centre for the day. Three residents told the inspector that they were happy in their home. They said that they liked their bedrooms and the house in which they lived. They said that staff were nice and that they could approach them if they had any concerns. They said that they liked their fellow residents. They talked about the activities that they engaged in and that they enjoyed. They said that they could meet their families and spend time with friends. They talked about the plans to repaint the centre and that they were looking forward to changing the colours in the centre. One resident became distressed when they met the inspector. They said that they were unhappy that another new member of staff was starting in the centre and that there had been a lot of staff changes lately. The inspector explained that they were not a member of staff but that they were inspecting the centre that day. Another resident reported that they

were not happy in the centre and that they wanted to move to a new house. They said that there were too many doors slammed in the centre. There were plans for this resident to move bedrooms within the centre and they said that they hoped this was only temporary until they found a new house. The person in charge reported that the resident had met with a social worker to support them identify new accommodation but that there were no other accommodation options in the locality at present. The person in charge said that they would ask the social worker to meet with the resident again.

Staff were observed interacting with residents in a friendly and caring manner. They were quick to respond when a resident asked for help. They were noted offering choices to residents at different times during the inspection and respecting their choices. In conversation, staff demonstrated knowledge of the measures that should be taken to reduce negative interactions between residents and to promote their safety.

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

Capacity and capability

The provider had identified the need to address service improvements issues in the centre. New systems of oversight and staffing arrangements had been introduced in response to some audit findings. However, significant improvement was required in relation to the oversight and management of service improvement plans. The inspector also noted that service improvement issues had been identified through a change of circumstances in the centre, rather than through the provider's regular monitoring systems.

Local management arrangements in the centre had changed in the recent weeks prior to the inspection. The provider had appointed the regional service manager as person in charge of the designated centre on a temporary basis. An acting service manager had been appointed in the centre to oversee the day-to-day running of the service. A team leader was also appointed to support the acting service manager. The inspection was facilitated by these individuals.

The person in charge reported that there had been considerable changes to staffing in the centre in recent months. This was due to the replacement of staff vacancies and a change to the number of staff on-duty to support residents. The provider had introduced additional staff support in the evenings. This formed part of the provider's safeguarding plan. Additional staff were on-duty to reduce negative interactions between residents during the transition of a new resident to the service. The provider had also changed the night staff arrangements. A waking night staff was appointed in addition to the sleepover staff that was already in place. The

waking night staff were provided through an agency and the same staff members covered these shifts so that they were familiar to the residents. The person in charge reported that a recruitment campaign was underway to fill three vacancies so that those shifts could be covered by staff employed directly by the provider. One person had been offered a post and there were plans to fill to the other two vacancies in the near future. As many staff were new to the service and the residents, the provider had changed the rostering arrangements so that the acting manager or team leader were on duty in the evenings to support and supervise staff. They had also increased the frequency of team meetings from monthly to fortnightly. The inspector reviewed the minutes from the last team meeting and noted that relevant information was shared with staff relating to the care and support of residents. An on-call rota of senior managers was available at weekends should any issues arise. The inspector reviewed the training records in the centre and found that staff were up to date in their training in the modules that were identified as mandatory by the provider. In response to issues that had been identified in the service, additional on-site training had been provided for staff in relation to medication management and supporting residents manage their behaviour.

Due to recent staffing changes and changes to the service, a number of service improvement issues had been brought to light. This had resulted in the provider implementing additional oversight arrangements in the centre. The effectiveness of these arrangements formed part of the inspection. The inspector reviewed recent audit and internal reviews that had been completed by the provider into the quality and care of the service delivered in the centre. The provider had completed a two-day audit on 11 September 2022 and 12 September 2022. The person in charge reported that this audit had been requested by local management. Therefore, this was not an unannounced audit of the service as outlined in the regulations. As a result of this audit, 49 separate actions were identified as service improvement targets. However, neither the audit nor the subsequent action-tracking document identified the person who would be responsible for the completion of the action nor a target timeframe for completion of the action. On the day of inspection, only three of the 49 actions were recorded as complete.

The provider had also completed a documentation review of the residents' personal plans and records of daily notes. This review had identified a number of issues relating to individual residents. These issues included the need to follow-up on medical appointments and medical test results, addressing complaints in line with the provider's policy, and safeguarding issues. Although the issues had been identified by the provider, the necessary actions needed to address these issues, the person responsible and the target timeline had not been recorded.

In response to the service improvement issues that had been identified, the provider had introduced a weekly governance meeting in the centre. Members of local management and members of senior management within the organisation were represented at these meetings. The meetings commenced on 14 October 2022 and a second meeting had occurred on 25 October 2022. No meeting had been held in the week prior to the inspection. The minutes of the first meeting were reviewed by the inspector. These minutes highlighted the issues that had been identified in the

centre during the recent audit and documentation review. Additional issues relating to the management of residents' finances were also identified. The minutes noted that some service improvement issues had already been commenced or addressed. For example, it had been identified that residents were contributing to the cost of lawn maintenance but that there was no record of an agreement between the provider and residents in relation to this. In light of the absence of an agreement, this practice had been stopped immediately. However, in relation to the other service improvement issues, the minutes from the meeting did not outline a specific or comprehensive plan to address these issues. Though broad targets had been identified, there were no specific actions recorded. In addition, a named individual or timeline for the completion of the service improvements had not been identified.

In conversation with local management, it was clear that there were additional service improvement projects underway in relation to the refurbishment of the centre. These actions formed part of the safeguarding plans in the centre. Staff outlined that the maintenance department had visited the centre to plan refurbishments. They also informed the inspector that there were plans for various tradespeople to attend the centre to complete tasks that had been identified. There were also plans to purchase new furniture for one house. However, again, this plan had not been recorded or documented. There were no definitive dates identified for the completion of these works and no individual staff member had been identified as the person responsible for ensuring that this plan was implemented.

The arrangements for the management of complaints were reviewed. Through the documentation review, the provider had identified that a number of complaints had been made by residents but that there was no record that these had been progressed in line with the provider's policy. The inspector reviewed the centre's complaints log. Although some complaints were recorded, the log did not identify that the complaints had been progressed or resolved in line with the provider's policy. The person in charge reported that a cyber-attack had occurred within the organisation a number of months prior to the inspection. As a result, the usual computer system used to track and progress complaints was not available. A new system had been obtained and was due to be implemented the following week. However, the interim arrangements for the processing of complaints had not been adequate to ensure that complaints were dealt with appropriately.

A sample written agreement between residents and the provider was reviewed. For one resident who had moved into the centre in recent months, the agreements had not been signed by the provider or resident. The agreement outlined the fees and bills that would be the responsibility of the resident. As outlined above, the provider had identified that residents were paying for certain items that were not outlined in their agreement and this was under review by senior management. The provider was in the process of redrafting local financial procedures to address the issues identified. A copy of the new policy was sent to the inspector via email following the inspection.

It was noted that appropriate notifications had not been submitted to the Chief Inspector in relation to the change of person in charge of the centre. As mentioned above, the person in charge was on extended leave at the time of inspection and a

temporary person in charge had been appointed. The necessary notifications regarding this matter had not been submitted in line with the timeframes set out in the regulations.

Through the recent audit process, documentation review and governance meetings, it was clear that the provider had identified the need for service improvement. They had taken a proactive approach to address these issues. However, the absence of a coherent and overarching service improvement plan negatively impacted on the provider's ability to monitor the service. In the absence of specific timeframed goals, the provider was unable to provide assurances that issues identified were being progressed or addressed in a timely manner. In addition, the service improvements had been identified due to a change of circumstances in the centre rather than through the provider's routine auditing and monitoring. It was noted that the provider was dealing with the effects of a cyber-attack at the time of inspection. However, it was clear that the interim systems of oversight had not been adequate to detect the necessary service improvements or shortcomings in governance processes.

Regulation 15: Staffing

The provider had reviewed the staffing arrangements in the centre in response to changing needs of the residents. The number of staff had been increased to reflect the needs of residents. There had been considerable changes in staff in the centre in recent months. However, the provider had taken steps to employ a core team of staff who were familiar to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were up to date in relation to training in modules that the provider had identified as mandatory for all staff. Additional training had been provided for staff in response to issues that had been identified in the service and in relation to the changing needs of residents.

Judgment: Compliant

Regulation 23: Governance and management

The provider had identified a number of significant service improvement issues. These issues had come to light due to recent changes in circumstances in the

centre, rather than through the provider's routine monitoring and oversight. It was noted that the provider had introduced new governance arrangements to address the service improvement issues that had been identified. However, the provider had not devised a specific, timeframed plan to address the issues noted. In the absence of a coherent and comprehensive plan, the provider was unable to ensure that the necessary actions to improve the service were identified or implemented in a timely manner. This negatively impacted on the ability to monitor the service.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had a written agreement in place with residents. However, the agreement between a resident who recently moved to the service and the provider was not signed on the day of inspection. Although the agreement outlined the fees that residents would have to pay, the provider had identified that residents were paying fees that were not outlined in the agreements. A new local financial policy was devised in response to this but a specific plan in relation to the written agreements had not been finalised on the day of inspection.

Judgment: Not compliant

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

The provider had failed to notify the Chief Inspector of changes to the person in charge in the centre in line with the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre's complaints log was reviewed. The log recorded some of the complaints in the centre. However, the progression or resolution of the complaints was not recorded in the log. The provider had identified a number of complaints that had been made by residents that had not been recorded or progressed.

Judgment: Not compliant

Quality and safety

The provider had taken proactive steps to protect residents' safety. This included steps to prevent safeguarding incidents, safe medication management and supporting residents manage their behaviour. However, improvement was required in relation to documentation relating to the refurbishment of the centre and residents' personal plans.

As discussed previously, there were areas in the centre that required refurbishment. The inspector reviewed the centre's maintenance record and noted that certain issues had been recorded as reported to the maintenance department. However, follow-up actions and plans to address the identified issues were not always recorded. The person in charge reported that there were plans to repaint all rooms in the centre, to replace existing showers with electric showers, retile bathrooms with more slip-resistant tiles and to completely refurbish the upstairs bathrooms. This would involve removing the bath and replacing it with a shower. It was reported that some of the relevant tradespeople had been contacted in relation to these works.

Refurbishment works were identified as elements of open safeguarding plans in the centre. It was identified that one of the kitchen-dining areas needed new furniture to provide additional space to residents and reduce negative interactions. In addition, there were plans to convert an underused room upstairs in one house into a second sitting room. It was planned that this room could be used for residents to enjoy beauty treatments, watch television and as a room where they could receive visitors without disrupting other residents. The person in charge and acting senior manager outlined the plans for these works to the inspector and the need to complete the works were noted in the residents' safeguarding plans. However, no specific refurbishment plan had been devised and there were no specific target dates for the completion of these works.

The acting service manager reported that a meeting was planned between residents and an advocacy service to support residents identify refurbishment works that they would like to have completed in the centre. The purpose of the meeting was to support residents write to the landlord of the house to request that the works be completed. However, again this was not documented. Due to the absence of an overarching plan, it was unclear how this meeting would impact on the planned refurbishments that were reported by members of local management.

In relation to safeguarding, it was noted that the provider had taken proactive steps to ensure residents' safety and reduce negative interactions. The inspector reviewed a sample of notifications that had been submitted to the Health Service Executive's (HSE) safeguarding team. There was evidence that safeguarding incidents had been reported appropriately and that the provider had developed safeguarding plans to prevent a reoccurrence of incidents. The safeguarding plans outlined the planned refurbishment works, the changes in staffing and plans for residents to access supports from relevant healthcare professionals. There was evidence that referrals

had been made to these healthcare professionals. Safeguarding plans were discussed at the staff team meeting on 8 November 2022. Staff were knowledgeable on the steps that should be taken to reduce and prevent safeguarding incidents in the centre. The acting service manager reported that a member of the HSE's safeguarding team had attended the centre on the 17 October 2022 and met with all residents.

Residents had access to supports in relation to managing their behaviour where required. A behaviour support therapist had met with some residents to complete an assessment and support them manage their behaviour. The provider had also accessed the support of additional relevant healthcare professionals to support residents with their behaviour. This included the support of an occupational therapist and a social worker. Behaviour support plans had been devised where required. A sample was reviewed by the inspector. The plans identified what might cause residents to become upset and how to support residents to remain calm. It also identified ways to support residents' manage their behaviour if they became distressed. The behaviour therapist had provided staff training workshops in recent weeks and months. This was to provide general information to staff on how to support residents manage their behaviour. In addition, there were training sessions provided on specific residents' behaviour support plans. The behaviour support therapist attended the team meetings in the centre and it was planned that this would continue for a further six months. The provider maintained a log of any restrictive practices that were implemented in the centre. There was evidence that residents were included in the decisions relating to these restrictive practices and had given their consent to their implementation. The log was regularly reviewed.

A sample of residents' personal plans and care plans were reviewed. Residents had care plans that outlined the supports they needed to meet their health, social and personal care needs. It was noted that one resident's annual assessment of need had been completed in early October 2022. However, their care plans and support plans were devised in September 2022 and had not been reviewed following this assessment.

The arrangements for the management of risk in the centre was reviewed. There was a risk register that outlined the risks in the centre and the service as a whole. This had recently been reviewed and updated. In addition, individual residents had risk assessments that guided staff on how to reduce risk to residents. A review of a sample of these assessments found that they were relevant to the individual resident, gave clear guidance to staff and were recently reviewed.

The provider had taken steps to improve the practice of safe medication management in the centre in light of incidents that had occurred a number weeks previously. The provider had completed a report into the existing practices that were in the centre. An audit of all incidents relating to medication was also completed. This resulted in the identification of a number of actions that needed to be completed to improve medication management in the centre. There was evidence that a number of these actions had been completed. For example, staff had received additional training and all medication dispensed in the centre was signed by two

staff members.

Overall, the inspector found that the provider was taking positive steps to meet the needs of residents. This included measures to protect their safety and support residents to manage their behaviour. However, improvement was required in relation to the documentation of the care needs of residents to ensure that staff had the most up-to-date information to guide practice. The centre itself also required considerable upkeep and improvement in line with the residents needs and to ensure that safeguarding plans were fully implemented. As no refurbishment plan had been devised, it was unclear when or how these issues were going to be addressed.

Regulation 17: Premises

The provider had identified areas within the centre that required refurbishment. Members of local management reported on planned works to certain areas within the centre. They reported that the maintenance department and a number of tradespeople had been contacted to commence these works. However, the maintenance log in the centre did not record actions that had been taken to address issues that were identified. There was no refurbishment plan in place that identified what actions were required, when they would be addressed or who was responsible for the oversight of their completion.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was a risk register in the centre that identified risks to the service and guided staff on how to reduce these risks. The register had been updated in recent weeks prior to the inspection. Individual residents also had risk assessments in place. These were recently updated and specific to the needs of residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had completed a review of the practices related to medication management in the centre. An audit of incidents relating to medication had been undertaken and actions for service improvement were identified. There was evidence that these actions had been implemented to good effect by the provider.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had individual care plans that guided staff on how to support residents with their health, social and personal care needs. However, improvement was required to ensure that these records were kept up to date and included all relevant information to guide staff.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents had access to relevant healthcare professionals to support them manage their behaviour. Where required, residents had detailed behaviour support plans to guide staff on how to support residents. Additional training had been provided to staff on supporting residents manage their behaviour. Where restrictive practices were in use, residents had given their consent for these to be implemented and the practices were regularly reviewed.

Judgment: Compliant

Regulation 8: Protection

The provider had taken proactive steps to protect residents' safety. This included a review of staffing arrangements to reduce negative interactions between residents. Staff were knowledgeable on steps that should be taken to protect residents. However, not all aspects of residents safeguarding plans were fully implemented and the provider could not provide specific dates and times when this would occur. For example, there was no specific date for the completion of a new visitor's room to allow residents receive visitors without disrupting other residents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Lifford Accommodation OSV-0002678

Inspection ID: MON-0038192

Date of inspection: 10/11/2022

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: - An Acting Manager was appointed to the centre on the 18th of October 2022. - The current PIC was appointed to the centre on the 18th of October 2022. - The current management arrangements for the center have been clearly defined and communicated with all of the team on the 7th of November 2022 by the current PIC - A number of Governance and Oversight meetings were held on the 24th October 2022, 11th of November 2022, & 29th of November 2022, and these were attended by the Director of Care, the Head of Operations, Senior Project Executive, Acting Manager, and current PIC. - Governance and oversight meetings will be held monthly for the next 6 months from January 2023' to June 2023, and will be attended by the Director of Care, the Head of Operations, the Director of Quality and Governance, the Acting Manager, and the PIC, to review the on-going performance of the center and ensure thorough oversight of Governance at all levels in to the future - The service improvement plan reviewed by the inspector on the 10th of November 2022 has been updated on the 17th of November 2022 to ensure a more detailed, clearly defined action plan is in place within the service - This service improvement plan will be reviewed weekly by the Acting Manager and Team Leader, and fortnightly between the Acting Manager and PIC until all actions are closed by the 31st of March 2023. - Team meetings were scheduled and held with the team on the 21th of October, 8th of November & the 6th of December. The team meetings were facilitated by the PIC, Team Leader and Acting Manager with the input of MDT such as the Behavioral Therapist. - Team meetings are for the future scheduled to occur every 6 weeks and will be facilitated by the Team Leader, Acting Manager, and current PIC will attend periodically. The dates of all team meetings are displayed in the service and have been communicated to all staff on the 14th of December 2022. - A standardized agenda is in place for all team meetings as of the 8th of November to	

ensure that there is clear communication around the required operations of the service, lines of accountability and persons who hold responsibility for any actions identified
- The Team Leader completed a weekly audit of the service. These have been completed weekly and are scheduled for each week with a clear plan in place in the service demonstrating this. This plan was put in place on the 7th of November 2022.
- The Team Leader weekly audit template will be updated by the Quality and Governance Directorate to include and thorough review and sign off of all daily notes, complaints, etc. This is to be completed by the 15th of January.
- The Acting Manager completes a monthly monitoring audit where the minutes of team meetings are reviewed and any actions identified are reviewed as being completed – these audits were completed on the 28th of October and the 30th of November. The December Audit was completed on the 18th of December. A schedule of these audits has been planned in advance for 2023 and is available in the service.
- All new staff have received a thorough induction to the service using the organizational induction template. This was completed by the 15th of December 2022.
- The contingency plan for the service has been updated to reflect clearly the arrangements should the PIC, Acting Manager, etc. are not on duty on the 14th of December 2022.
- Service Users have monthly key working sessions which are facilitated by their key worker. Dates for key working sessions have been put in place and are planned in advance with all key workers and residents.
- Coaching for all key workers was completed by the Acting Manager and Team Leader. This will be completed for all staff by the 20th of January 2022.
- The weekly and monthly auditing processes for the monitoring of the center will be updated by the Quality and Governance Directorate to include areas such as a review of sample of daily notes, identification of any gaps in reporting of incidents or complaints, etc. This will be completed by 15th January 2023 and will be in use from January 2023 in all Designated Centre's.
- The Acting Manager, Team Leader and current PIC are working with the Talent Acquisition Department to ensure a plan is in place to ensure that any outstanding resources will be in place by the 15 of February 2023.
- The 6 monthly unannounced template will be reviewed by the Quality and Governance Department to include a review of daily notes etc. This will be completed by 15th of January 2023.
- The 6 monthly provider monitoring visit will be unannounced in 2023 and onwards.
- The Annual Review template has been updated by the Quality and Governance Department to include the review of admissions to the centre and the effectiveness of the plans that were in place in supporting new admissions. The Annual Review has commenced for the service and will be completed by the 15th of January 2023.
- A support and supervision schedule has been implemented in the service where staff have had fortnightly support and supervision up to the 30th of November 2022. A quarterly supervision schedule is in place for 2023, in line with Rehab Care Policy and Procedure, with support and supervision sessions for staff being shared between the Team Leader, Acting Manager/PIC. All staff have received in advance the support and supervision schedule on the 15th of December 2022
- The Complaints and Safeguarding of Vulnerable Adults processes have been discussed with all staff at team meetings on the 8th of November 2022.
- At the team meeting on the 20th of December all staff will be informed of the processes that they can follow to raised concerns and the channels in which they can do

so.
- A suite of training is being delivered by members of the Quality and Governance Department before the 20th of January and will further cover Complaints, Safeguarding of Vulnerable Adults, Regulation Training, and any other relevant components required and identified by the provider or in this HIQA report.
- The current PIC has reviewed the Notification periods that apply to the notification of the change of PIC and the requirements of the provider in relation to this.
- The Provider has circulated the HIQA Notification's Handbook to all PIC's and remind them of the requirements to report events to HIQA, this was completed by 14th December 2022.
- The statement of purpose and function was updated to clearly define the current operational governance arrangements on the 15th of December 2022.
All compliance actions will be validated by the PPIM/Regional Manager/Acting PIC on the providers Vi-Clarity quality improvement monitoring system once the actions have been uploaded and completed by 31st of March 2023.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
- An up to date written contract was provided to all residents by the provider on the 15th of December 2022.
- The details of the financial arrangements within the designated centre, including resident and provider contributions, have been included in the written contracts provided on the 21st of November 2022.
- The up to date written contract was reviewed with each resident in line with their individual needs by the Team Leader/Acting Manager by the 21st of November 2022
- Updated tenancy agreements have been provided to all residents on the 15th of December 2022 by Newgrove Housing Association.
- The updated tenancy agreement provided on the 15th of December outlines clearly the areas that the resident and provider contribute to.
- The updated tenancy agreements will be reviewed with each resident in line with their individual needs by the Team Leader/Acting Manager by the 20th of December 2022.
- Each resident has had an up to date financial support plan put in place by the 22nd of November by the Team Leader/Acting Manager. These plans clearly outline all the financial supports and arrangements for each resident, and, their contributions and rent paid.
- The Statement of Purpose and Function for the service has been updated on the 15th of December to clearly outline the financial arrangements in the centre relating to the provider and the residents, and where these can be located for each resident.
All compliance actions will be validated by the PPIM/Regional Manager/Acting PIC on the providers Vi-Clarity quality improvement monitoring system once the actions have been uploaded and completed by 31st of March 2023.

Regulation 32: Notification of periods when the person in charge is absent	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:
- The required notification related to the PIC was submitted on the 14th of November 2022
- The subsequent required information was sent by the provider to the regulator on the 2nd and 6th of December 2022.
- The current PIC has reviewed the Notification periods that apply to the notification of the change of PIC and the requirements of the provider in relation to this.
- An Acting Manager was appointed to the centre on the 18th of October 2022
- The current PIC was appointed to the centre on the 3rd of October 2022
- The current management arrangements for the center have been clearly defined and communicated with all of the team on the 7th of November by the current PIC
- A number of Governance and Oversight meetings were held on the 24th October 2022, 11th of November 2022, & 29th of November 2022, and these were attended by the Director of Care, the Head of Operations, Senior Project Executive, Acting Manager, and current PIC.
- Governance and oversight meetings will be held monthly for the next 6 months from January 2023' to June 2023, and will be attended by the Director of Care, the Head of Operations, the Director of Quality and Governance, the Acting Manager, and the PIC, to review the on-going performance of the center and ensure thorough oversight of Governance at all levels in to the future
- The service improvement plan reviewed by the inspector on the 10th of November 2022 has been updated on the 17th of November 2022 to ensure a more detailed, clearly defined action plan is in place within the service
- This service improvement plan will be reviewed weekly by the Acting Manager and Team Leader, and fortnightly between the Acting Manager and PIC until all actions are closed by the 31st of March 2023.
- Team meetings were scheduled and held with the team on the 21th of October, 8th of November & the 6th of December. The team meetings were facilitated by the PIC, Team Leader and Acting Manager with the input of MDT such as the Behavioral Therapist.
- Team meetings are for the future scheduled to occur every 6 weeks and will be facilitated by the Team Leader, Acting Manager, and current PIC will attend periodically. The dates of all team meetings are displayed in the service and have been communicated to all staff on the 14th of December 2022.
- A standardized agenda is in place for all team meetings as of the 8th of November to ensure that there is clear communication around the required operations of the service, lines of accountability and persons who hold responsibility for any actions identified
All compliance actions will be validated by the PPIM/Regional Manager/Acting PIC on the providers Vi-Clarity quality improvement monitoring system once the actions have been uploaded and completed by 31st of March 2023.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- The provider has reviewed the process for the monitoring and resolution of complaints within the service. This was to determine whether there were satisfactory or unsatisfactory outcomes for the complainant, and to strive to resolve issues raised by residents or their representatives.
- All complaints logged from January 2022 will be uploaded by the Acting Manager to the organizational Complaints Monitoring and evaluation system, ViClarity which was implemented on the 21st of November 2022 nationally.
- All complaints in the service from January 2022, will be uploaded onto the ViClarity monitoring system by the Acting Manager by the 31st of December 2022.
- All staff have received up to date information on the process for recording complaints locally on the 15th of December 2022
- Each resident has a support plan which determines how they communicate so that staff can clearly identify how best to support a resident to make a complaint. All support plans have been reviewed by the Acting Manager/Team Leader by the 22nd of November 2022.
- A suite of training is being provided by organisations Quality and Governance Directorate with the organizational Complaints Officer providing training to the team before the 20th of January 2023.
- Resident meetings are scheduled to take place before 30th of December 2022 where complaints will be discussed and residents will be informed of the process on how to make a complaint and who they can raise their complaint to.
- A copy of the orgnaisational complaints policy will be issued to all immediate family members by the 20th of December 2022.
- Complaints is on the Team Meeting standardized agenda and was discussed at team meetings on the 21th of October, 8th of November & the 6th of December with all staff.
- The organizational complaints policy and procedure was last reviewed on the March 2021 and has been read and signed by all staff by the 15th of December 2022. The policy and procedure is due for next review in March 2024.
- Where required, both Rehab Advocacy Services and the National Advocacy Services are deployed to support residents where they have issues or concerns. The Rehab Advocacy Services attended the service on the 23rd of November 2022 to meet with residents. 1 of 6 residents have been referred to the National Advocacy Services by the 30th of November in line with their will and preference.
- An accessible version of the complaints policy will be devised by the organizational Complaints Officer by the 31st of March 2023 and distributed to all residents.
- Complaints are monitored on a weekly basis by the Team Leader. A weekly Team Leader Audit schedule is in place as of the 16th of December 2022.
- Complaints are monitored by the Acting Manager/PIC on a monthly basis. The Acting Manager completes a monthly monitoring audit where the minutes of team meetings are

reviewed and any actions identified are reviewed as being completed – these audits were completed on the 28th of October and the 30th of November. The December Audit was completed on the 18th of December. A schedule of these audits has been planned in advance for 2023 and is available in the service.
- Complaints are reviewed as part of the 6 monthly unannounced monitoring visit by the provider.
- Complaints are reviewed as part of the Annual Review by the Regional Manager. The Annual Review for 2023 has commenced and will be finalized by the 31st of December 2023.
- Where required the provider engages the supports of multidisciplinary professionals and others involved in service users lives with their consent in resolving complaints where required. Evidence of this is available within the service.
- The complaints officer is clearly displayed in the service as the Team Leader/Acting Manager as of the 30th November 2022.
All compliance actions will be validated by the PPIM/Regional Manager/Acting PIC on the providers Vi-Clarity quality improvement monitoring system once the actions have been uploaded and completed by the 31st of March 2023.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- The statement of purpose was reviewed by the Acting Manager on the 15th of December 2022. This clearly identifies the layout of the designated centre.
- The planned change of an unutilized space to a visitor's room/relaxation room for residents to enhance the quality of their environment and the space available to them in their home to have visits with their families, without impact on other residents. This will be completed by the 31st of January 2023.
- The main areas of the house, including the hallways, kitchens and living rooms are currently under some environmental enhancements including painting – this will be completed by the 28th of February 2023.
- Newgrove Housing Association are aware that the kitchens require refurbishment works in both houses. This will be completed by the 31st of March 2023.
- Newgrove Housing Association are aware that the bathrooms all require upgrade – this will be completed by the 31st of March 2023.
- In line with best practice all residents will be supported to have involvement in the decision making around the aesthetics of their home through resident's meetings which occur monthly. A schedule of resident's meetings is in place as of the 15th December 2022.
- Residents are supported to make personalized enhancements to their private accommodation such as their bedroom. Action plans are in place as of the 6th of December A monthly key working schedule is in place for each resident as of the 22nd of November and maintenance will be discussed with residents during key working as relevant and escalated to the Team Leader/Acting Manager by the key worker/resident monthly where relevant.

- An up to date maintenance log is in the centre and was completed by the Team Leader/Acting Manager on the 22nd of November. The maintenance log will be reviewed weekly by the Team Leader and monthly by the Acting Manager/PIC.
- Maintenance issues are escalated to Newgrove Housing as they arise and a request for a formal update on works is requested by the Acting Manager/PIC each month.
- Where there are barriers to the completion of works – these are escalated by the Acting Manager/PIC to the Regional Manager to resolve, and where required will escalate to the Head of Accommodation/Director of Care to seek resolution and action.
- Records and evidence of the progression of all works, capital or otherwise, is held locally in the service as of the 6th of December with evidence of escalation and the process of same.
All compliance actions will be validated by the PPIM/Regional Manager/Acting PIC on the providers Vi-Clarity quality improvement monitoring system once the actions have been uploaded and completed by the 31st of March 2023

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:
- All staff will receive coaching from the Team Leader / Acting Manager in relation to PCP and Support Planning by the 15th of January 2022
- All individuals residing in the designated centre have had a review of their comprehensive assessment of need conducted in conjunction with the Team Leader/Acting Manager by the 7th of November 2022.
- The comprehensive assessment of need that has been reviewed for each resident by the Team Leader/Acting Manager, by the 7th of November 2022 is clearly recognisable and identifies the individual health, personal and social care needs of each resident. The outcome of this assessment has been used to inform an associated plan of care for each resident and this is recorded as the resident's personal support plans.
- Where required personal support plans have been reviewed in conjunction with the input of multidisciplinary professionals involved in the overall support needs of each individual. This was completed by the Team Leader/Acting Manager by the 22nd of November 2022.
- Multidisciplinary Professionals have recommended works to be completed in the centre, namely in the bathroom and kitchen areas, so that the premises are suitable for the purposes of meeting the assessed needs of each resident. These works have been notified to Newgrove Housing Association and will be completed by the 31st of March 2023.
- Where relevant, the service has worked with residents and, with the consent of residents, with their representatives to identify their strengths, needs and life goals. This was completed by the Team Leader/Acting Manager by the 7th of November 2022. These goals (outcomes) will be progressed in conjunction with staff who support residents, and be monitored by the Team Leader and Acting Manager in the completion

of their auditing. These will also be reviewed as part of the provider 6 monthly unannounced monitoring visit.
- Multidisciplinary reviews of the person plans/needs of relevant individuals are all up to date as of the 22nd of November 2022.
- All action plans have a time scale, persons responsible for supporting residents, and are actively monitored as of the 22nd of November 2022.
- Personal plans are reviewed at a minimum annually.
- Key working and the progression of action plans is completed by the key worker monthly, and, reviewed and a sample are monitored by the Acting Manager/PIC monthly.
All compliance actions will be validated by the PPIM/Regional Manager/Acting PIC on the providers Vi-Clarity quality improvement monitoring system once the actions have been uploaded and completed by the 31st of March 2023.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
- All residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. This is planned through key working for each resident by the 15th of January 2022.
- Protection is discussed at all resident's meetings which take place each month facilitated by the Team Leader/PIC and staff who support residents.
- The planned change of an unutilized space to a visitor's room/relaxation room for residents to enhance the quality of their environment and the space available to them in their home to have visits with their families, without impact on other residents. This will be completed by the 31st of January 2023.
- Safeguarding of Vulnerable Adults was discussed with all staff at the team meeting on the 8th of November 2022 by the Team Leader/Acting Manager and current PIC.
- Protection/Safeguarding of Vulnerable adults forms a standard agenda item on the team meeting agenda.
- At the team meetings, which are scheduled in advance as of the 14th of December and communicated to all staff on the 14th of December, safeguarding plans are discussed and reflection on practice and implementation occurs. This is evidenced in team meetings that occurred on the 21th of October, 8th of November & the 6th of December and will continue to be facilitated by the Team Leader/Acting Manager at all future team meetings where safeguarding or protection concerns have occurred in the timeline between team meetings.
- All staff have completed mandatory training in relation to the safeguarding of vulnerable adults by the 7th of November 2022.
- A suite of training is being provided by organisations Quality and Governance Directorate with the organizational Complaints Officer providing training to the team before the 20th of January 2023.
- The HSE Safeguarding Team Leader visited the service on the 25th of October 2022 and met with residents and staff.
- A review of all Safeguarding submissions and plans was completed with the

Safeguarding Team Leader on the 18th of November.
- There have been no Peer to Peer safeguarding concerns in the service since the 4th of November 2022.
- The designated officer and their contact details is clearly displayed in the centre.
All compliance actions will be validated by the PPIM/Regional Manager/Acting PIC on the providers Vi-Clarity quality improvement monitoring system once the actions have been uploaded and completed by the 31st of March 2023.

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 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.	Not Compliant	Orange	31/03/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/03/2023
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident	Not Compliant	Orange	31/03/2023

	is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 32(1)	Where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more, the registered provider shall give notice in writing to the chief inspector of the proposed absence.	Not Compliant	Orange	15/11/2022
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	31/12/2022
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	22/11/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022