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:	Grange View Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	18 January 2023
Centre ID:	OSV-0004063
Fieldwork ID:	MON-0034937

About the designated centre

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

Grange View provides a residential service to people with an intellectual disability and who require mild to high support needs. The centre has capacity to accommodate five residents at any one time and six residents were identified as using this service. Four of the residents have a full-time placement and two residents had a shared care arrangement. The centre is located on the outskirts of a small town and transport was provided in the evenings and weekends for residents to attend their local community for activities and events. There is a social care model applied in this centre and there are staff on duty, both in the morning and in the evening. Residents are also supported by one night duty staff member.

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
Wednesday 18 January 2023	09:30hrs to 16:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to follow up on issues identified at the last inspection and to monitor ongoing compliance with the regulations.

On arrival at the centre, staff on duty guided the inspector through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene and face covering.

The designated centre comprises a single storey house located on the outskirts of a rural village and provides a service for up to six residents. Four of the residents have a full-time placement and two residents have a shared care arrangement. The inspector met with four of the residents, staff working in the centre, the team leader and the recently appointed person in charge. All residents normally attended day services during the weekdays.

On the morning of inspection the inspector met with three residents who were getting ready to leave the centre to attend their respective day services. While residents were unable to tell the inspector their views of the service, they appeared to be content and happy to be going to their day service. They smiled as they waved goodbye to staff in the centre. Two staff from the day services had arrived in the centre to support residents travel by bus to the local day service. Staff reported that residents had been supported with personal care, had their breakfasts and had their packed lunches in line with their normal weekday routines.

Grange View Services has good access to a number of larger towns, a range of facilities and amenities. Accommodation is provided for residents in five individual bedrooms. One of the residents has a bedroom with ensuite toilet and shower facilities, as well as a separate living and dining area. Other residents shared a bathroom, shower room, sitting room and dining room. Residents had access to an enclosed well-maintained garden area with an outdoor dining space provided to the rear of the dwelling. Improvement works had been carried out to the premises since the previous inspection, new flooring had been provided to the communal areas, most parts of the building had been repainted and some further improvements works were in planned. The centre was found to be visibly clean, warm and decorated and furnished in a homely style. Residents bedrooms were comfortably decorated, suitably furnished and personalised. Bedrooms had adequate storage for personal belongings and were personalised with items of significance to each resident including family photographs and other items of significance to individual residents. Staff advised that new flooring had been approved for one bedroom and painting of other bedrooms was planned.

The inspector noted adequate staff on duty to support the needs of residents. One resident had been assessed as requiring 1:1 staffing support. Staff spoken with were satisfied with the current staffing arrangements. Staff knew the residents well, many reporting that they had worked for several years with the residents in the centre.

Staff were very knowledgeable regarding the individual needs, likes, dislikes and interests of the residents.

The person in charge had been recently appointed to the role and was still getting to know residents and the service. They were positive in attitude and showed a willingness to ensure that a good quality and safe service was provided for residents. They had identified and were progressing a number of areas for improvement. However, the inspector had concerns that the provider had not ensured that effective arrangements were in place to support, develop and oversee the person in charge in their role. This is discussed further under the capacity and capability section of this report.

Staff reported that residents continued to be supported to engage in meaningful activities in the centre and in the local community. They advised that residents continued to enjoy a variety of activities going for walks, shopping, visiting the local church, going on day trips, getting takeaway meals, attending local events such as football matches, recent tractor run and local farmers market. They reported that residents enjoyed eating out, music sessions, Jacuzzi baths and exercise sessions while attending day services. They reported that residents enjoyed relaxing at home, watching television, listening to music, helping out with household tasks and assisting with gardening activities. The centre had its own minibus which could be used by residents to attend outings and activities. The inspector observed a number of photographs of residents enjoying recent outings and activities.

The inspector met with four residents on their return to the centre during the afternoon of the inspection. They appeared to be relaxed and comfortable in their environment as they greeted staff in their own ways. Residents were observed enjoying the interaction and company of staff. Some residents set about their own routines, others were supported promptly by staff to have cups of tea and snacks while another was supported with personal care. Staff informed the inspector that they planned on getting a takeaway meal from a local restaurant in line with the usual Wednesday evening routine. They spoke of how the residents enjoyed and looked forward to this weekly treat. There was evidence that residents continued to be consulted regarding their preferred meal options at the weekly house meetings. Minutes of meetings reviewed showed that food and menu choices were discussed weekly. Staff were knowledgeable regarding the nutritional needs and dietary requirements of residents. There was clear guidance available to staff regarding residents who required modified and specialised diets in line with the recommendations of the speech and language therapist (SALT). Staff had completed training on feeding, eating, drinking and swallowing difficulties (FEDS).

Residents' rights were promoted and a range of easy-to-read documents, posters and information was supplied to residents in a suitable format. For example, easy-to-read versions of important information on COVID-19, infection prevention and control protocols including techniques for hand washing as well as staffing information were made available to residents. Staff had established residents' preferences through the personal planning process, house meetings, and ongoing communication with residents and their representatives.

In summary, the inspector observed that residents were treated with dignity and respect by staff. There were stable staffing arrangements in place and staff were well known to the residents. It was evident that staff and the local management team prioritised the welfare of residents. However, many deficits were noted to the providers governance and management arrangements, and further oversight and improvements were also required to fire safety management, restrictive practice documentation, personal planning documentation, to individual risk assessments and to ensuring that referrals to allied health services were acted upon promptly.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

This unannounced inspection was carried out to

- monitor compliance with the Regulations
- follow up on non-compliance's identified at the previous inspection
- following notification of a change to the person in charge.

The findings from this inspection identified a number of significant failings in relation to the provider's governance and management arrangements.

There were inadequate and ineffective arrangements in place to support, guide and oversee the recently recruited person in charge in their role. The Chief Inspector had been notified of a change to the person in charge who had commenced in the role on 28 November 2022, this notification was still under consideration at the time of inspection. The provider had failed to support them by ensuring a comprehensive handover, orientation and induction process. There was no mentoring arrangements in place and inadequate supports provided to ensure that the person in charge understood their roles and responsibilities, reporting lines, and made aware of the policies and procedures to be followed to ensure a safe and quality service. This was of concern given that the person in charge was new to the role and to the disability services and responsible for the management and oversight of safety and care in the centre.

There were no formal arrangements in place to support staff out of hours during the weekdays. This was of concern given that there was up to five residents and only one staff member on duty at night time. This posed a risk to both staff and residents particularly in the event of an emergency at night time. While the person in charge advised that they would be willing to support staff in an emergency, the provider had not supplied them with a mobile telephone, therefore, staff could not contact them out of hours.

The person in charge worked full-time and was supported locally by the team leader

who was allocated six administration hours a week. They advised the inspector how they had been working collaboratively on identifying areas for improvement, had completed some improvements while others were work in progress. For example, the statement of purpose had been updated to reflect the recent changes to the local management arrangements in the centre, personal emergency evacuation plans had been updated for all residents and they were currently updating risk assessments and documentation to support the assessment of residents needs.

Systems in place for reviewing the quality and safety of care in the centre required review. While the provider had recently completed an audit in November 2023 and identified a number of areas for improvement, there was no evidence that the provider had carried out unannounced audits at least every six months in line with the regulations. Areas for improvement identified during the November audit had been addressed or were in the process of being addressed. There were no other audits or reviews available, for example, reviews of medicines management, infection, prevention and control and fire safety management were not available. The provider had failed to fully implement its own compliance plan which was submitted to the Chief Inspector following the last inspection. For example, there was no evidence that hand hygiene assessments had been regularly completed, or that audits of equipment and cleaning products had taken place.

The person in charge spoke of their plans of putting an audit schedule in place in order to assist them in maintaining oversight of the quality and safety of care in the centre. The person in charge planned to hold monthly staff meetings to discuss the results of audits, share learning and ensure that any improvements identified were addressed.

On the day of inspection, there were sufficient staff on duty to support the residents assessed needs in line with the statement of purpose. Staff spoken with were satisfied with the staffing arrangements and advised that there were no current staff vacancies. There were normally three or four staff on duty in the morning and evening time depending on the number and needs of residents, there was one staff on duty at night time.

Staff training records reviewed indicated that all regular staff had completed mandatory training including fire safety, safeguarding and behaviour management. Additional training in various aspects of infection control, epilepsy, administration of medications, respiratory emergency, feeding eating and swallowing difficulties and managing chemical agents hazards. However, there were no training records available for relief staff who worked sometimes in the centre. The person in charge was in the process of updating all staff training records and putting a training plan in place for 2023. Further training was scheduled in relation to fire safety and medicines management.

Regulation 15: Staffing

Staffing levels and mix were in line with that set out in the statement of purpose.

The staffing roster reviewed indicated that there was a regular staff pattern of consistent staff to ensure continuity of care. The staffing roster was properly maintained clearly showing staff on duty during the day and night time.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training records reviewed indicated that all regular staff had completed mandatory training including fire safety, safeguarding and behaviour management. Additional training in various aspects of infection control, epilepsy, administration of medications, respiratory emergency, feeding eating and swallowing difficulties and managing chemical agents hazards. Further training was scheduled in relation to fire safety and medicines management.

Judgment: Compliant

Regulation 23: Governance and management

There were inadequate and ineffective arrangements in place to support, guide and oversee the recently recruited person in charge in their role. The provider had failed to support the recently appointed person in charge by ensuring a comprehensive handover, orientation and induction process. There were inadequate supports provided to ensure that the person in charge understood their roles and responsibilities, reporting lines, and made aware of the policies and procedures to be followed to ensure a safe and quality service. This was of concern given that the person in charge was new to the role and to the disability services and responsible for the management and oversight of safety and care in the centre.

There were no formal arrangements in place to support staff out of hours during the weekdays. This was of concern given that there was up to five residents and only one staff member on duty at night time. This posed a risk to both staff and residents particularly in the event of an emergency at night time. While the person in charge advised that they would be willing to support staff in an emergency, the provider had not supplied them with a mobile telephone, therefore, staff could not contact them out of hours.

Systems in place for reviewing the quality and safety of care in the centre required review. There was no evidence that the provider had carried out unannounced audits at least every six months in line with the regulations. There were no audits or reviews available, for example, reviews of medicines management, infection, prevention and control and fire safety management.

The provider had failed to fully implement its own compliance plan which was submitted to the Chief Inspector following the last inspection. For example, there was no evidence that hand hygiene assessments had been regularly completed, or that audits of equipment and cleaning products had taken place.

The provider had failed to ensure that effective fire safety management systems were in place. The person in charge had not received training or guidance on the workings of the fire alarm and the layout zones in the building. This was of concern given that they were responsible for the safety of residents and staff in the centre.

Further oversight was required in relation to restrictive practices and supporting documentation to ensure compliance with national policy and evidenced based practice.

Further oversight was required to personal planning documentation and to ensure that when services provided by allied health professionals were required by a resident that access to such services was provided.

Judgment: Not compliant

Regulation 21: Records

There were no training records available for relief staff who worked sometimes in the centre.

Judgment: Substantially compliant

Quality and safety

The local management team and staff strived to ensure that residents received an individualised, safe and good quality service, improvements identified at the previous inspection in relation to infection, prevention and control had been largely addressed. However, as discussed under the capacity and capability section of this report, inadequacies identified in relation to the overall governance and management arrangements had the potential to impact negatively on the quality and safety of the service provided. Further oversight and improvements were also required to fire safety management, restrictive practice documentation, personal planning documentation, to individual risk assessments and to ensuring that referrals to allied health services were acted upon.

The inspector reviewed a sample of residents' files and noted some inconsistencies in the personal planning documentation. Residents health care needs had been assessed using validated tools, however, some risk assessments including skin

integrity and falls risk assessments were out-of-date and required updating to reflect the current needs of residents. The person in charge outlined that with the support of the team leader that they were currently updating risk assessments and documentation to support the assessment of residents needs. Care and support plans were in place reflecting residents needs. Personal plans had been developed in consultation with residents, family members and staff. Recent meetings had taken place and short term goals had been set out in action plans. However, goals set out were vague and non specific, did not identify the names of persons responsible for pursuing objectives in the plan within agreed timescales. There were no formal review meetings scheduled to discuss progress and review the effectiveness of the plans.

Residents had access to general practitioners (GPs), out of hours GP service, consultants and a range of health and social care professional services. All residents had recently had their annual medical review. A review of a sample of residents files indicated that some residents had been reviewed by a range of healthcare professionals including psychologist, speech and language therapist (SALT), behaviour therapist, dentist and physiotherapist. However, further oversight was required to ensure that referrals and assessments requested by staff were followed up and responded to. For example, a referral to the physiotherapist and psychologist in March 2022 for a resident had not been responded to. Residents had been supported to avail of vaccination programmes. Each resident had an up-to-date hospital passport which included important and useful information specific to each resident in the event of the required admission to hospital.

Staff had received specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm. There were detailed personal and intimate care plans to guide staff. The support of a designated safeguarding officer was also available if required. The inspector noted that residents who required support with behaviours of concern had plans in place outlining strategies to support them. Staff reported that there had been no recent safeguarding incidents or concerns and that safeguarding plans in place were working well. Records reviewed showed that staff had requested a review of one residents psychological and behaviour guidelines in March 2022 and again in May 2022, however, it had not been responded to at the time of inspection. All staff had completed training in the management of behaviours that challenged. Residents who required supports with communication had plans in place which were tailored to their individual communication preferences and support needs.

Improvements and further oversight were required in relation to restrictive practice supporting documentation to ensure compliance with national policy and evidenced based practice. Staff spoken with confirmed that there were a number of restrictive practices in use on a regular basis. While there were protocols in place for their use, there was no evidence available to show a multidisciplinary input and rationale into the decision taken to use the restraints, or to show that other alternatives were tried or considered. There were no records available to show when these restrictions were in use or the duration of their use. The use of all restrictive procedures

continued to be reviewed by the restrictive practice committee.

Improvements required to the physical environment as identified during the previous inspection had been addressed. New flooring and skirting boards had been provided, the walls to much of the house had been repainted. Staff outlined that further improvement works were planned including the replacement of flooring to a bedroom, repainting of some bedroom walls and the replacement of some kitchen appliances.The inspector noted some evidence of dampness to a wall behind a bed in one bedroom which required investigation and repair, paintwork to some items of bedroom furniture was chipped and in need of repainting.

The house were found to be visibly clean and improvements were generally noted in relation to infection prevention and control. There was a comprehensive cleaning manual in place to guide staff and a colour coded and flat mop cleaning system in place. Cleaning records of morning, evening and night time cleaning tasks were being maintained. There were adequate supplies of cleaning products and cleaning equipment was suitably stored. Suitable hand drying facilities had been provided at all wash hand basins. Following the last inspection, staff had completed training in hand hygiene and in managing health and safety in healthcare (chemical agents hazards). However, the provider had failed to fully implement its own compliance plan which was submitted to the Chief Inspector following the last inspection. For example, there was no evidence that hand hygiene assessments had been regularly completed, or that audits of equipment and cleaning products had taken place as outlined by the provider in the compliance plan response.

While the staff team demonstrated good fire safety awareness and knowledge of the evacuation needs of residents, the provider had failed to ensure that effective fire safety management systems were in place. The person in charge had not received training or guidance on the workings of the fire alarm and the layout zones in the building. This was of concern given that they were responsible for the safety of residents and staff and oversight of fire safety management in the centre. The fire equipment had been serviced in June 2022. The fire alarm was being serviced on a quarterly basis. Daily, weekly and monthly fire safety checks were being recorded. Fire exits were observed to be free of obstructions. Training records reviewed indicated that all staff had completed fire safety training. Regular fire drills had been completed simulating both day and night time scenarios. While the times taken to evacuate up to four residents provided assurances that residents could be evacuated safely and in a timely manner, there had been no fire drill to simulate the evacuation of the maximum number of five residents when only one staff member was on duty.

Regulation 17: Premises

Some further improvements were required to the physical environment. Staff outlined that works were planned including the replacement of flooring to a bedroom, repainting of some bedroom walls and the replacement of some kitchen

appliances.

Dampness evident to a wall behind a bed in one bedroom required investigation and repair, painted wooden bedroom furniture was chipped and in need of repainting.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The house were found to be visibly clean and improvements were generally noted in relation to infection prevention and control. There was a comprehensive cleaning manual in place to guide staff and a colour coded and flat mop cleaning system in place. Cleaning records of morning, evening and night time cleaning tasks were being maintained. There were adequate supplies of cleaning products and cleaning equipment was suitably stored. Suitable hand drying facilities had been provided at all wash hand basins. Following the last inspection, staff had completed training in hand hygiene and in managing health and safety in healthcare (chemical agents hazards). However, the provider had failed to fully implement its own compliance plan which was submitted to the Chief Inspector following the last inspection. There was no evidence that hand hygiene assessments had been regularly completed, or that audits of equipment and cleaning products had taken place as outlined by the provider in the compliance plan response. This is included as an action under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had failed to ensure that effective fire safety management systems were in place. The person in charge had not received training or guidance on the workings of the fire alarm and the layout zones in the building. This was of concern given that they were responsible for the safety of residents and staff and oversight of fire safety management in the centre. There had been no fire drill to simulate the evacuation of the maximum number of five residents when only one staff member was on duty at night time, therefore, the Chief Inspector could not be assured that all residents could be evacuated safely in a timely manner in the event of fire or other emergency at night time.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Improvements were required to the personal planning documentation. Some risk assessments reviewed including skin integrity and falls risk assessments required updating. Goals set out in personal plans were vague and non specific, did not identify the names of persons responsible for pursuing objectives in the plan within agreed timescales. There were no formal review meetings scheduled to discuss progress and review the effectiveness of the plans.

Judgment: Substantially compliant

Regulation 6: Health care

Improvements were required to ensure that when services provided by allied health professionals are required by a resident that access to such services is provided. A review of a residents file indicated that a referral to the physiotherapist and psychologist in March 2022 had not been responded to.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Improvements and further oversight was required in relation to restrictive practices and supporting documentation to ensure compliance with national policy and evidenced based practice. Staff spoken with confirmed that there were a number of restrictive practices in use on a regular basis. While there were protocols in place for their use, there was no evidence available to show a multidisciplinary input and rationale into the decision taken to use the restraints, or to show that other alternatives were tried or considered. There were no records available to show when these restrictions were in use or the duration of their use.

Judgment: Not compliant

Regulation 8: Protection

Staff had received specific training in the protection of vulnerable people. There were comprehensive and detailed personal and intimate care plans to guide staff. The support of a designated safeguarding officer was also available if required. Residents who required support with behaviours of concern had plans in place outlining strategies to support them. Staff reported that there had been no recent safeguarding incidents or concerns and that safeguarding plans in place were

working well.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported by staff to live person-centred lives where their rights and choices were respected and promoted. The privacy and dignity of residents was well respected by staff. Staff were observed to interact with residents in a caring and respectful manner. Information was available to residents in a suitable accessible format. Residents continued to be consulted with and weekly house meetings took place. Residents religious rights were catered for and staff supported some residents visit the local church and attend church ceremonies.

Judgment: Compliant

Regulation 26: Risk management procedures

There were no formal arrangements in place to support staff out of hours during the weekdays. This was of concern given that there was up to five residents and only one staff member on duty at night time. This posed a risk to both staff and residents particularly in the event of an emergency at night time.

The person in charge had not received training or guidance on the workings of the fire alarm and the layout zones in the building which posed a risk to residents and staff.

The risk register was not up to date. The person in charge outlined how she had requested training on risk assessment and on the quality management information system(QMIS). This training had taken place earlier on the week of inspection and the person in charge advised that she was in the process of reviewing incidents, risk assessments and updating the risk register.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 26: Risk management procedures	Not compliant

Compliance Plan for Grange View Services OSV-0004063

Inspection ID: MON-0034937

Date of inspection: 18/01/2023

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:
PPIM met the PIC and held a support meeting on 31st January 2023 . At this meeting the PPIM has provided clear guidance and direction in relation to the management structure and the staff team detailing various roles and responsibilities , reporting structure and the communication and escalation pathways .
PIC will attend additional training workshops which are scheduled over the next three months .
A schedule of support meetings for 2022 has been agreed with the PPIM

Person in Charge and Person Participating in Management will be reviewing and monitoring the governance and management issues for the service on a weekly basis.

A revised 7/7 on-call structure has been identified by the Senior Management Team, and arrangements for this are currently being finalised. It is intended that the new on-call arrangements will be communicated across services and implemented by end of March 2023.

Internal Management Audit system put in place. Daily, weekly and monthly audits will be completed by the team along with the support of the team leader and PIC. This internal audit system was implemented on 3rd February 2023.

A review and update of assessment of needs of all service users was completed on 2nd February 2023.
Resident personal plans have been updated by the keyworkers and reviewed by the PIC and Team Leader. All appointments have now been scheduled with all relevant health services as part of health checkups.

Ability West is currently completing a review of all resident assessment of needs and

following this review, the changing needs of residents will be identified and reviewed. This review will be completed by the end of April 2023.

All outstanding referrals have been followed up on and all relevant documentation is now available on site. Follow-up appointments have also been scheduled where required for any service user. A clear pathway is now available in terms of accessing healthcare support both internally and externally.

Restrictive Practice log has been put in place on 1st February 2023 and evidence for restrictive practices are in place
Multi-Disciplinary Team meeting minutes are available on site in relation to the residents.
A copy of the National policy on restrictive practice is available on site and this has been read by Person in charge on 21st February 2023.
Person in charge has read the Ability West restrictive practice policy.
Person in charge is aware of the process of implementing restrictive practice in line with Ability West policy.

Training has been provided in relation to the fire system and layout zones in the residence on the 30th January 2023 . A new layout map has been ordered in relation to the clear marking of zones.

Provider led audits were completed on 27th May 2022 and 9th November 2022 and are available on site . Action and compliance plans in relation to the Provider led Audits or HIQA inspections will be discussed and reviewed by the PIC and PPIM on the weekly meeting
The action and compliance plans will also be discussed at staff meetings

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Training Records are now available for all relief staff on site. Training matrix also available as of 2nd February 2023

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review has been completed by PIC and PPIM, all required work has been identified and PPIM has contacted Ancillary Services Manager to schedule and complete work.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Training was provided to PIC in fire systems, PIC training was provided by Cube(Fire Company) fire panel and layout zones in the residence 30/01/23, PIC has discussed and shown full process of full fire procedure with all staff on the 9/02/2023.

Fire Drill completed on 02/02/23 to simulate one staff member evacuating the maximum number of five residents to reflect night duty evacuation plan. Effective and safe fire

evacuation conducted.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: A review and update of assessment of needs for all service users was completed on 2nd February 2023 All individual and centre risk assessments have been reviewed and updated on 20th January 2023 Resident personal plans have been updated by the keyworkers and reviewed by the PIC and Team Leader. All appointments have now been scheduled with all relevant health services as part of health checkups. Ability West is currently completing a review of all resident assessment of needs and following this review, the changing needs of residents will be identified and reviewed. This review will be completed by the end of April 2023.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: A review and update of assessment of needs of all service users has been completed on 2nd February 2023. All outstanding referrals have been followed up on and all relevant documentation is now available on site. Follow-up appointments have also been scheduled where required for any service user. A clear pathway is now available in terms of accessing healthcare support both internally and externally. Access to healthcare supports externally and internally will be an agenda item on the weekly meeting between the Person in charge and person participating in management.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Restrictive Practice log has been put in place on 1st February 2023 and evidence for restrictive practice are in place . Multi-Disciplinary Team minutes are all available on site in relation to the residents. A copy of the National policy on restrictive practice is available on site and this has been read by Person in charge on 21st February 2023. Person in charge has read the Ability West restrictive practice policy. Person in charge is aware of the process of implementing restrictive practice in line with Ability West policy.	

Restrictive Practices will be an agenda item on the weekly meeting between the Person in charge and person participating in management.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Out of hours support for staff confirmed for weekdays out of hours – PPIM available Monday to Friday out of hours and on call system available at the weeks. All risk assessments completed and up to date following review, completed on 23rd January 2023. The risk register been updated accordingly to reflect the current situation and risks in the designated centre. Training received in fire system and layout zones in the residence 30th January 2023, New layout map ordered in relation to the clear marking of zones.	

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.	Substantially Compliant	Yellow	28/04/2023
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	28/02/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit	Not Compliant	Orange	30/05/2023

	to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	28/02/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for	Not Compliant	Orange	28/02/2023

	responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	28/02/2023
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	28/02/2023
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, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	28/02/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive	Substantially Compliant	Yellow	28/02/2023

	assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	28/02/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	28/02/2023
Regulation 05(7)(c)	The recommendations arising out of a	Substantially Compliant	Yellow	28/02/2023

	review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	28/02/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	28/02/2023