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:	No.3 Brooklime
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	21 September 2023
Centre ID:	OSV-0005145
Fieldwork ID:	MON-0041526

About the designated centre

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

No.3 Brooklime consists of a detached bungalow located on the outskirts of a town and within close driving distance to a city. The centres provides residential care for a maximum of five female residents, over the age of 18, with intellectual disabilities including those with autism who have multiple/complex support needs that may require support with behaviours that challenge. While some residents live in the centre full-time, on some nights other residents avail of the centre on an alternating basis. Each resident has their own individual bedroom and other rooms in the centre include a kitchen, a dining room, a utility room, two living rooms and a staff bedroom-office. Support to residents is provided by the person in charge, social care workers and care assistants.

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
Thursday 21 September 2023	13:50hrs to 21:50hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

During this inspection, it was evident that residents were following a specific schedule while present in this centre. This schedule was intended to reduce the potential for residents to impact one another. Despite this there were indications that residents could still negatively impact one another and that the environment provided was not best suited to residents individual needs.

This designated centre had a capacity for five residents and while there were some days when all five residents were in the centre together, there were times when some residents stayed in their family home. On the day of inspection four residents were present in the centre while the fifth resident was with their family. All four of the residents present during the inspection were met by the inspector. These four residents did not communicate verbally and none of them interacted directly with the inspector during his time in the centre.

When the inspector arrived at the centre, no residents or staff members were initially present but two staff members quickly arrived to commence their shifts. Three of the residents were away from the centre attending day services elsewhere operated by the same provider. The fourth resident was generally supported from the centre but was on an outing when the inspector arrived. It was indicated to the inspector that attempts had been made to support this resident to attend a day services in recent months but that this had not worked out so they were continuing to be supported from the centre.

The premises that made up this centre was seen to be reasonably presented and furnished during the inspection although some markings were evident on one wall. The centre had two living rooms, a kitchen, a dining room and a utility room with residents also having access to a garden with some decking. In keeping with the capacity of the centre, there were five individual bedrooms available for residents' use. The inspector saw three of these bedrooms and noted them to be nicely furnished but it was noted that these bedrooms varied in size with the largest bedroom being over twice the size of the smallest.

Aside from reviewing the premises, the inspector spent most of the initial stages of the inspection speaking with staff and management of the centre. During this time the four residents returned to the day services. After their return some residents were supported with meals while others spent time in their bedroom or in the two living rooms of the centre. At one point the inspector saw that a staff member was supporting a resident with a meal. .

Around this time some music was playing and it was seen that one resident carried a tablet device with them listening to some songs. While this resident was present in the centre during the centre, it was seen that the resident did this regularly and would tend to listen to the same songs repeatedly. It was indicated to the inspector that the use of the tablet device in this way by this resident could impact another

resident who preferred a quiet low stimulus environment. This resident's personal plan also referenced them not liking loud noises while three other residents' personal plan also referenced them not like noise or things being busy.

Despite this, the centre was regularly described to the inspector as being busy and multiple staff also referenced the centre the centre being loud at times. It was also indicated that in response to this a specific shift planner was being followed in the centre which was intended to limit the impact that residents could have on one another. This shift planner set out a schedule for all five residents of what they were do every day from 8am to 10pm. This shift planner was referred to as "intensive staggering" by the provider's rights review committee and will be discussed in more detail elsewhere in this report.

The shift planner was seen to be followed on the day inspection and all staff spoken with were aware of this. However, despite this there was some evidence that residents did negatively impact one another. For example, in the months leading up to this inspection there had been a noticeable increase in safeguarding incidents between residents in the centre. Staff indicated that they were kept busy trying to keep residents apart and highlighted how the layout of the centre's premises did not always help with this. It was also indicated by multiple staff that one resident was engaging in self-injurious behaviour due to the noise in the centre.

As the inspection progressed it was seen that all residents left the centre at certain points. One resident was collected by their relatives to go for an overnight stay in their family home while the other three residents went out for drives and walks. This did reduce the level of noise in the house at times but during the last few hours of the inspector the three remaining residents had all returned to the centre and there was more noise in the centre particularly from a resident's tablet device. Around this time, the resident who preferred a quiet low stimulus environment was seen sitting in the one of the centre's living rooms in the dark with most lights there turned off.

The shift planner continued to be followed at this time and as part of this one resident was supported with a meal by a staff member while another resident was helped to have a shower by a second staff. While this was happening the third resident was seen present in the centre's kitchen with a third staff member. It was indicated by this staff member that this resident would want to go to the bathroom door while their peer was showering. In response to this the resident would be encouraged to remain in the kitchen. After this and as the inspection neared its end, it was seen that residents were supported with their night-time routines. When the inspector left the centre just before 10pm, all three residents were in bed.

In summary, some residents were indicated as not liking noise or busy environments but there were indications that this centre was a busy environment where noise was commonplace. This contributed to residents being negatively impacted and there being safeguarding incidents in the centre. It was also suggested by staff that the premises layout did not help prevent such incidents.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how

these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

While an organisational structure was in place for reporting, varying information provided suggested that this was not working effectively. Based on the overall findings of this inspection, the provider had not ensured that the centre was appropriate to residents' needs.

Registered until December 2025, this centre had previously been inspected by the Chief Inspector of Social Services in June 2023 with that inspection focused on the area of infection prevention and control practices. Since then the Chief Inspector had received some unsolicited information relating to this centre which raised concerns in areas such as safeguarding, residents' rights and governance of the centre. Given the nature of these concerns, the decision was made to conduct the current inspection which focused on these areas. As part of the inspection process the inspector observed practice, reviewed documentation and also spoke with management and staff of the centre.

The centre had an organisational structure in place which ran from front-line staff working in the centre to the provider's board of directors as was set out in the centre's statement of purpose. Having such a structure is important to ensure that there are clear lines of accountability and reporting. Despite this, there was indications that this structure was not working effectively with the inspector receiving varying information from management and staff around residents' quality of life in the centre. For example, one member of the centre's management indicated that they were being told that residents had a good quality of life but this was contrary to what staff told the inspector.

It was also indicated to the inspector by management that no staff had raised concerns around the quality of care provided to residents through the provider's internal processes. However, staff spoken with indicated that concerns were raised during regular staff meetings that happened in the centre. When asked by the inspector if there were any barriers to raising concerns in the centre, staff indicated that management were approachable and were trying their best. Despite this, multiple staff indicated that the support from management of the centre could be improved with concerns also raised around staff turnover given the challenges in supporting the needs of residents.

Under the regulations the provider is responsible for ensuring that the needs of residents are met. The evidence gathered during this inspection indicated that suitable arrangements were not in place to place to meet the needs of the residents. This will be discussed further elsewhere in this report. However, the provider did have a plan to make changes to the existing premises to meet support the needs of the residents living in this centre. This would involve building an extension to the

centre and subdividing the centre allowing different residents to live on either side of the centre. The inspector was shown a drawings of the proposed works. It was also indicated that at time of this inspection that this plan was awaiting input from a quantity surveyor.

Once this was obtained, progressing the works would still be subject to planning approval and it was indicated that completing the premises works could take 18 months. While a member of the centre's management indicated that funding was available to complete these premises works, there appeared to be a level of frustration from both staff and management in the time it was taking for this premises plan to progress. Management of the centre highlighted the impact that the COVID-19 pandemic had had on this plan while also highlighting that the provider was dependant on external bodies to progress this plan. While this was acknowledged, the inspector was provided with varying information around the length of time this premises plan had been under consideration.

During this inspection it was verbally indicated to the inspector by a member of management that the plan had been developed two years prior. In contrast, documentation reviewed during this inspection made clear reference to a recommendation being made in February 2019 for the centre to be subdivided in two and extended. At the feedback meeting for this inspection, the inspector sought clarity on this from management. It was subsequently communicated that long term recommendations around the premises were made in March 2021. While this was noted, it was also apparent from records reviewed during the inspection that concerns were raised around the environment and/or premises provided for residents in this centre prior to March 2021.

Regulation 15: Staffing

Given the needs of residents, each resident of this centre was to be provided with one-to-one staff support. It was indicated that this was generally in place but that there had been times when some short notice staff absence had not been replaced. The inspector was also informed that there was some staff vacancies in the centre at the time of inspection while staff spoken with also highlighted that there had been some staff turnover. This had resulted in more new relief staff working in the centre in recent months. Staff indicated that this posed challenges given the needs of residents living in the centre. However, it was acknowledged that there were staffing challenges affecting the health and social care sector generally while the provider was making ongoing recruitment efforts.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was being maintained that contained most of the required information but spaces in this directory to indicate the name of authority, organisation or body that arranged residents' admission to the centre were left blank.

Judgment: Substantially compliant

Regulation 23: Governance and management

While an organisational structure was in place for this centre, the varying information provided by staff and management suggested that this structure was not operating effectively regarding reporting. Staff spoken with also highlighted that support from management could be improved. Taking into account the overall findings of this inspection, the provider had not ensured that the centre was appropriate to residents' needs.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose reviewed on the day of inspection contained a copy of the centre's previous certificate of registration while details of the full-time equivalent staffing arrangements required review to ensure that they were accurate.

Judgment: Substantially compliant

Quality and safety

The needs of four residents were indicated as not being met in their current residential setting. A shift planner that was in place to support residents was found by the provider to be infringing residents' rights in their home. There had been a recent increase in safeguarding incidents between residents.

As discussed earlier in this report, some residents were indicated as not liking noise or busy environments but such elements were present in this centre. The inspector reviewed the personal plans of all five residents who availed of this centre with such plans intended to set out the needs of residents. These plans expressly indicated that that the current residential setting provided by this centre was not suited to meet the needs of four of the five residents. The premises plans for this centre were

intended to ensure that residents were provided with an environment that was more suited to their needs. However, even with that there were suggestions that the proposed reconfigured and expanded premises might not best the suits the needs of one resident who preferred a quiet low stimulus environment.

It was indicated to the inspector that this resident was on a residential risk forum which was described as being a working group within the provider to discuss resident compatibilities and vacancies in the provider's centres in the Cork area. The inspector was also informed that this resident had recently been discussed at the provider's admission, discharge and transitions (ADT) committee and that the resident was under consideration for a transition to another of the provider's other designated centres. This was subject to the completion of a compatibility assessment and multidisciplinary input before returning to the ADT committee while it was indicated to the inspector that the resident would be consulted as part of this process.

A referral for an independent advocate for this resident and their living environment and had been previously made in 2022 which received a consultation. One staff member spoken with suggested that management of the centre were not supportive of involving independent advocates for residents. Management of the centre strongly disputed this but did highlight the challenges in advocacy referrals being picked up and pointed towards most residents having families who could advocate on the residents' behalf. It was also indicated that another referral for an independent advocate for the resident and their living environment had been recently sent. Following the inspection it was further communicated that advocacy referrals for the other four residents were sent in 2022 and also received a consultation.

Aside from independent advocacy, the provider had its own rights review committee. The shift planner referenced earlier in this report had been recently referred to this committee for review. Records of the outcome of the review were seen by the inspector which indicated that the shift planner infringed all five residents' rights to freely and autonomously navigate their own home. It was also highlighted by staff that this shift planner impacted residents' rights in their home and one resident would have to move out of a communal area due to another resident coming into the same area. A recent incident report referenced such an instance where the resident was described as being removed from the kitchen to make space for another resident. The former resident was also described as protesting this.

It was acknowledged that this shift planner was introduced as a safeguarding measure, something which was also referenced by the rights review committee. However, despite this there had been a noticeable increase in safeguarding incidents in this centre in the two months leading up to this inspection. As a result there were a number of safeguarding plans active for the centre at the time of this inspection. All staff members spoken with were aware of such safeguarding plans. The safeguarding incidents that had occurred recently had involved instances of hair pulling and a resident waking a peer at night.

Discussions with some staff members suggested that there been more incidents of residents waking up peers at night. The information provided verbally did not correspond with safeguarding notifications submitted to the Chief inspector. During the feedback meeting for the inspection, this was queried with management of the centre. It was subsequently communicated following the inspection that there were no other documented matters of concern in this regard. The safeguarding incidents that were documented coupled with the other evidence reviewed during this regard suggested there was incompatibility amongst the residents in this centre.

Regulation 5: Individual assessment and personal plan

One resident was highlighted as preferring a quiet low stimulus environment while some residents were indicated as not liking noise or busy environments. However, the centre was described to the inspector as being busy and loud at times. Accordingly, the personal plans of four residents expressly indicated that that the current residential setting provided by this centre was not suited to meet these residents' needs. While the provider was considering the transition of one resident and had a wider premises plan for this centre, at the time of the current inspection, suitable arrangements were not in place to meet the needs of residents.

Judgment: Not compliant

Regulation 8: Protection

There had been seven safeguarding incidents between residents in the two months leading up to this inspection. These had involved instances of hair pulling, grabbing and a resident waking a peer at night. These incidents represented a noted increase in safeguarding incidents for this centre and suggested there was incompatibility amongst the residents in this centre which was contributing to such instances.

Judgment: Not compliant

Regulation 9: Residents' rights

The shift planner that was being followed in this centre infringed all five residents' rights to freely and autonomously navigate their own home.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for No.3 Brooklime OSV-0005145

Inspection ID: MON-0041526

Date of inspection: 21/09/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider has ensured that • the number, qualifications and skill mix of staff is appropriate to the needs of the residents in this centre. • Where staffing vacancies have been identified, the services recruitment process has been engaged. • There is currently one vacancy within the centre that has been advertised through the Services human resource office and staff will be appointed to these contracted roles following successful recruitment. This role has been previously advertised, however the position has not been filled due to the recruitment challenges affecting the health and social care sector. 30/04/2024 • The PIC has ensured that there is a regular relief staff (familiar to the residents) in place to support the long term vacancy and unexpected/short notice leave. The PIC continuously reviews and recruits as required. 18/10/23 • In the event of short notice staff absence, the PIC has ensured a risk assessment is on the centres risk register to support minimum safe staffing. This is reviewed regularly. 18/10/2023	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The registered provider has ensured that • There is an established and maintained directory of residents in this centre. Information in this directory has now been included to indicate the name of the	

authority, organization or body that arranged residents' admission to the centre.
18/10/2023

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The service has a clear line management structure as identified in the centre's Statement of Purpose. The provider will ensure the following for effective governance:

• The Area Manager and the PIC will remain in weekly (more often if required) contact and in the absence of the Area Manager the PIC will contact the Sector Manager.
• The PIC sets out an action plan following Team meetings and updates are provided. Staff will be asked to put forward their views to the meeting for clarity for all concerned.
• The Sector Manager/Area manager will provide regular updates on the proposed building project. This will set out the timeline from when the desirability of the extension was first mentioned through to the time is was agreed that this should be a priority for facilities planning and elevation to Senior Management. The Project timeline will include time spent in consulting with MDT on the specifications and the various stages of building project management.
• The PIC/SCL is available to the staff team when they are on duty. The frontline team can also contact the area manager/sector manger directly should they require assistance in the absence of the PIC/SCL. This reporting structure is evidenced on the staff notice board within the centre.
• The service has identified an out of hours on call support arrangements as per the centre's Statement of Purpose.
• Following consultation with the frontline staff team, the area manager will attend this support and supervision meeting quarterly to ensure that the structure is operating effectively regarding reporting. This in turn will also provide support from management to the front-line team. 11/10/2023

To ensure the service provides a safe environment and is apppopriate to residents needs and is consistanly and effectively monitored, the provider will ensure that:
• Following consultation with the frontline staff team, the area manager will attend this support and supervision meeting quarterly to ensure that the structure is operating effectively regarding reporting. This in turn will also provide support from management to the front-line team. 11/10/2023
• The Service provider also ensures that there is six monthly provider audits completed in this centre. Last audit completed 26/10/2023
• The registered provider has ensured the following:
- One resident was screened as suitable for an identified vacancy within the services by the Provider Admissions, Discharges and Transfers Team on 17/10/23. The resident will

now be asked if they wish to consider this transfer and if so they will be supported through the Services Transfer Process.
- The development of a transition plan will commence following consultation with and agreement by the resident and assuming a successful transition the resident will move into the identified centre on the week of the 11/12/2023.
- The registered provider has developed an interim plan with the services facilities manager to develop structural works to support dividing the centre to meet the needs of the remaining residents. 31/01/2024
- The registered provider is finalising a longer-term plan with the services facility's manager in consultation with the frontline staff team and the residents to extend the current footprint of the centre. 31/3/2025
• All persons residing in this centre were referred to an advocacy service requesting their support in relation to 'Where I live' in May 2022. The PIC made a referral for one resident to an advocacy service on the 29/08/2023 and will follow up with this referral by the 31/10/23. Further referrals will be made on behalf of the remaining residents by the 30/11/23.

• The Provider will conduct a review the pathways to planning from the resident risk committee to ensure that priority changing needs are identified at this forum and are escalated appropriately. 15/12/2023

• The original shift planner was referred to service rights review committee, which found that although the intensive staggering plans infringed upon residents' rights in this centre, that whilst not ideal do appear least restrictive and for least duration. All recommendations received in these reports have been implemented.18/10/23. The provider will ensure that the system of reporting adverse findings from by the rights review committee is shared with the relevant Sector manager at the point of issue. 31/10/2023.

• This centre has a rostered fortnightly support and supervision meeting that is chaired by the SCL/PIC where the agenda has been developed via staff and management input.
• The area manager holds regular support and supervision meeting with Social Care Leader/PIC to review the fortnightly minutes from the centre's meeting. Any actions arising from same that can't be address locally will be elevated through the line management system.
• The organisational structure also provides formal supervision six monthly to all staff and more often if required or requested.
• The register provider has a policy in place that ensures the service supports formal reporting via the services procedure for raising a grievance.
• The register provider has a policy in place where residents can be supported to make a complaint.
• The provider has ensured there are policies and procedures in place to guide staff to ensure the effective quality and safety of the services that they are delivering.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The register provider will ensure that a review of the statement of purpose has taken place, to include updating the certificate of registration and a review of the details provided in relation to the full-time equivalent staffing arrangements. 23/10/2023

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The registered provider in conjucntion with the PIC will:
The PIC and the frontline team will review each residents personal profile every six monthly or more often if required.
• Each resident has an appointed keyworker that updates and reviews the personal profile plans. This involves organising annual Positive Outcome Measures with the resident and their families to develop meaningful goals and activities for the resident as per the residents will and preference. The key worker further links with the PIC and the residents day service to ensure an holistic approach in supporting the resident to achieve their goals. These goals are reviewed regularly (at minimumly on a six monthly basis) and progress is documented to outline the development of these goals.
• The PIC shall ensure an annual multidisciplinary review of the each residents personal profile. This review includes:
- consultation and participation of each resident,
- progress/barriers on actions arising from previous year's AMDT review
- financial oversight
- allied health review of current plans and new assessments,
- goals and support plans
- day service provision
- open risk assessments
- restrictive practices
- safeguarding
• The registered provider has ensured a system is in place to identify, assess and manage risk within this centre. The PIC with support from the frontline team continue to review a comprehensive assessement of need for each resident, highlighting risk and control measures required to support maximum participation for each resident according to their will and preference. The PIC and the frontline team discuss known and arising risks through support and supervision meetings fortnightly and effectiveness of control measures. Where risk is not managed at a local level for the residents of this centre, it is escalated through the services line management structure.
• To ensure residents reside in a quiet low stimulus environment the following is

planned:
- One resident was recommended as suitable for an identified vacancy within the services following an admission discharge and planning meeting took place on the 17/10/23. This transfer option will be discussed with the resident.
- If the resident is willing to consider this transfer the development of a transition plan will commence and assuming a successful transition the resident will move into the identified centre on the week of the 11/12/2023.
- If this resident does not wish to take up this option the placement will be offered to one of the other residents if deemed suitable in an attempt to reduce the business of the Centre.
- The registered provider has developed an interim plan with the services facilities manager to develop structural works to support dividing the centre to meet the needs of the remaining residents. 31/01/2024
- The registered provider is finalising a longer-term plan with the services facility's manager in consultation with the frontline staff team and the residents to extend the current footprint of the centre. 31/3/2025

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The service operates a zero tolerance in relation to matters of concern and the registered provider has ensured that systems in place support all residents to reside in this centre free from all forms of abuse. This evidenced by the following:

• The PIC has ensured that all staff in the centre have received appropriate safeguarding training and respond appropriately to the prevention, detection and response to incidents of concern.
• All matters that have an indication of a possible safeguarding concern as defined within the HSE and BOCSI national safeguarding policies and procedures of concern are notified to the services designated officer and to the inspectorate within the provided timeframes.
• As per the services procedures interim safe guarding plans are developed to proportionately respond to each individual concern.
• Following external oversight agreement on each preliminary screening and proposed interim safeguarding plan, formal safeguarding plans are in place and regularly reviewed at fortnightly support and supervision meetings with the local team.
The PIC ensures risk assessments are completed in relation to matters of concern as they arise and are identified on the centres risk register. Where control measures in place are not effective, risk is elevated through the line management structure. 18/10/2023
• The PIC has completed a service compatibility assessment with MDT support for one resident. Following an admissions, discharge and transfer meeting on the 17/10/23, it has been recommended that this resident is suitable to transfer to a vacancy to another centre if they so wish once the details of the placement are outlined to the resident. 11/12/2023

• The registered provider has developed an interim plan with the services facilities manager to develop structural works to support dividing the centre to meet the needs of the remaining residents. 31/01/2024
• The registered provider is finalising a longer-term plan with the services facility's manager in consultation with the frontline staff team and the residents to extend the current footprint of the centre. 31/3/2025

• Following a review based on the information as provided in the inspector's report, (see last paragraph under quality and safety) a meeting was held with the frontline team on the 11/10/23 with the Area Manager to verify if there were any other safeguarding concerns outside of the those reported. The front line team gave assurance to the Area Manager that all incident of concern have been reported accordingly.
• The numbers of reported notifications to the inspectorate have been reviewed in alignment with the documentation in the designated centre and the safeguarding register held in the designated office. These are accurate and up to date 11/10/2023

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The registered provider will ensure that each resident in accordance with their wishes has the freedom to exercise choice and control in their daily life.

• The person in charge following consultation with each resident will implement a personal daily and weekly choice of routines for each resident is this centre, taking in to account the resident likes and dislikes, preferred activities and their will and preferences. These routines will honor the resident's preference and choice on the day. This is supported by the recommendations of involved MDT and balanced with any identified risk.

• The original shift planner that was referred to service rights review committee, which found that although the intensive staggering plans infringed upon residents' rights, this planner is ceased. All recommendations received in these reports have been implemented. 18/10/23

• All persons residing in this centre were referred to an advocacy service requesting their support in relation to 'Where I live' in May 2022. The PIC made a referral for one resident to an advocacy service on the 29/08/2023 and will follow up with this referral by the 31/10/23. Further referrals will be made on behalf of the remaining residents by the 30/11/23.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/04/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	18/10/2023
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	11/10/2023

	details responsibilities for all areas of service provision.			
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	31/03/2025
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	18/10/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	23/10/2023
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that	Not Compliant	Orange	31/03/2025

	arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/11/2023