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:	The Willows
Name of provider:	Autism Initiatives Ireland Company Limited By Guarantee
Address of centre:	Wexford
Type of inspection:	Short Notice Announced
Date of inspection:	13 April 2021
Centre ID:	OSV-0005792
Fieldwork ID:	MON-0031041

About the designated centre

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

The Willows is located in a rural area of Co. Wexford, close to a small village. A large town, which has all services and amenities, is a short commute away. The house comprises of a three bedroom bungalow and a separate one bedroom apartment is on the same site. Both the bungalow and the apartment have their own private garden spaces and there is ample parking. The provider's stated objective is to provide 24 hour care to persons diagnosed with autism spectrum condition. The house provides full time support to one adult, who lives in the self-contained apartment. The main house provides care for four residents, with a maximum of three residents in the house at any one time. The aim of care, as set out in the centre's statement of purpose, is to provide person centred, tailored service appropriate to residents individual needs, wants and dreams. Increasing independence in skills for daily living is a core objective and staff actively encourage and promote social inclusion. Residents have access to daily activities and transport is available to facilitate such activities. Residents present with a broad range of needs in the context of their disability and the service aims to meet these requirements with physical, mobility and sensory support. The model of care is social and the staff team is comprised of social care workers and support workers, under the guidance and direction of the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 13 April 2021	11:00hrs to 17:30hrs	Margaret O'Regan	Lead
Tuesday 13 April 2021	11:00hrs to 17:30hrs	Sarah Cronin	Support

What residents told us and what inspectors observed

This inspection took place in the midst of the COVID-19 pandemic. Communication between inspectors, residents, staff and management took place from a two metre distance and was time limited. The inspectors had the opportunity to meet with two residents on the day of inspection, albeit this time was limited. The regulations prioritised for examination were those which provided the best evaluation of what this home was like for residents and what level of safety and care was afforded to residents by the staff and the organisation supporting them.

The centre comprised of a bungalow which had three bedrooms and a separate self contained apartment. One resident lived in the apartment. In general, the resident living in the apartment had a consistent cohort of staff, with some support from staff who worked in the main house. The resident frequently had 2:1 staffing levels. Inspectors did not have the opportunity to meet with this resident but were informed by the person in charge that the resident's overall wellbeing had improved over the previous few months. Having consistent staff working with this resident was an important feature of their care. In addition, the person in charge ensured staff completed a document called a "Personal Quality Enhancer" This was a particularly useful guide and monitoring system to ensure the resident received care in the manner that best suited them and staff had clear information on what those specific care needs were.

Primarily, the residents communicated in a non verbal manner. Their way of communicating was individual to each and was frequently expressed through their behaviours. Understanding these communications took time. Helping residents to develop their particular skills and build up trust between them and staff, also took time. The person in charge was keenly aware of this and was working through the challenges posed by a number of front line and management staff changes, that had occurred since the centre opened in 2019 and in particular, in the months prior to this inspection and since she was appointed in August 2020.

The house and its environs was well maintained. It was warm, nicely decorated, appropriately furnished and had a spacious garden. The person in charge spoke of year on year improvements to the premises such as the resurfacing of the parking area, the upgrading of one bathroom, the purchase of a second car and a new septic tank. A system was in place for the person in charge to secure funding support for any works that was necessary. Plans were in place to create a sensory garden and this was also to include an area where one of the residents could engage in art activities.

On arrival at the centre at 11:00am, inspectors were greeted by a resident, staff members, the person in charge and the area manager. A second resident was observed to be seated in the sitting room watching television. This resident acknowledged the inspectors and smiled. A third resident was in their apartment. Shortly afterwards the residents left for a day trip and returned in the late

afternoon.

On their return, one of the residents came and again greeted the inspectors. Staff informed inspectors that the resident had been for a walk, had gone horse-riding and afterwards had a coffee. The interaction between staff and the resident was noted to be warm and respectful and the resident appeared to be happy with their day's activities. Later in the afternoon, a resident was seen being supported by staff to hang out their laundry. They were observed to smile and laugh together. There was a sense that the resident was familiar with their surroundings and had a routine they followed. Residents looked comfortable in the company of staff.

Social stories were used to support residents' understanding of a variety of areas such as vaccination, attending appointments, visits from HIQA staff and understanding physical boundaries. Residents used Ipads and a visual schedule as a way of communicating and understanding what tasks and activities were going to take place throughout their day. These were individualised to reflect residents' understanding. There was documentation on how best staff should respond to particular phrases of a resident in order to support them. The person in charge spoke positively about how staff, who were familiar with the resident, were skilled at understanding these phrases.

The care provided in this centre was full time for the resident who lived in the apartment. A shared care arrangement was in place for a further two residents, whereby the residents lived in The Willows Monday to Friday, had their own bedrooms and at the weekends went to the home of family members. Two further residents stayed in the house for two nights each week. One of these residents stayed at the weekend and the other stayed two mid-week nights. In this way their stays did not overlap and both used the same bedroom. The person in charge described how this shared room was personalised for each resident. Before each resident came to stay their own personal effects were put in place, such as family photos and other personal possessions. The person in charge spoke of this being done with the aim of making the room as familiar and as homely as possible for each individual.

The provider had recently installed devices that worked on the principle of fingerprint recognition for persons to enter a room. The rationale for installing the technology was well intentioned and was in response to managing a situation whereby one resident had a tendency to enter other residents' rooms. It was unclear to the inspectors, if the system suited each of the residents involved as some were more skilled at utilising it than others. Given that it was still relatively new, a more comprehensive assessment of its appropriateness was needed at a later stage.

Inspectors viewed documented concerns raised by staff, in their role as resident advocates. These concerns arose when one resident was displaying behaviours that challenge, resulting in other residents not gaining access to toilet facilities in their house for over an hour. The incontinence experienced by residents on two such occasions compromised their dignity and privacy. Measures were put in place to minimise the risk of a similar such situation re-occurring. These included staff

training, supporting the resident during the crisis they were experiencing and finding alternative toilet facilities away from the house, should they be needed. No such similar instance had occurred in the previous few weeks but it was too soon to determine if the risk of a repeat situation had abated. Inspectors were not satisfied with the oversight of this matter. Neither were inspectors satisfied that the restrictive intervention of preventing access to the house and toilets, were being adequately regarded, assessed and reviewed as a restrictive practice.

In summary, this centre was aimed at providing the best support possible to each resident. The inspectors noted examples of where good care and support was provided and how it positively benefited residents' wellbeing and contentment. However, the major task was the challenge to build a consistent staff team as the centre had a high staff turnover. The person in charge, who was in post eight months, was hopeful that with more time, her influence and commitment to the role would pay dividends and the goal of individualised care and improved wellbeing for residents, would be achieved. Other improvements were found to be needed around the oversight of management practices, including the decision making process for the use of restraint and the impact to residents dignity by some of the restraint measures in place.

Capacity and capability

There were management systems in place; however, improvements were required to ensure these systems provided clarity and assurance that the service was safe and appropriate to residents' needs. The provider had carried out unannounced and announced inspections as per regulatory requirements at six and twelve month intervals and reports were provided to the inspectors. In addition to the provider's announced and unannounced inspections, the person in charge oversaw other reviews such as medication audits, health and safety checks and positive risk management audits. The annual and six months reports outlined areas for improvement but it was unclear if these had been actioned.

Inspectors noted that audits on restrictive practices were carried out and the use of restrictive practices had reduced; however, there was a lack of clarity as to how decisions were made with regards to the use of a restrictive measure. For example, the area manager spoke of plans to commence restrictive practice meetings but they had not commenced. Inspectors were not assured that there was proper managerial or organisational oversight on how decisions on the use of a restriction was made.

Notwithstanding that governance and management improvements were needed, there were many good aspects to the management systems in place. For example, monthly management team meetings took place. This was the forum where new items were discussed. The area managers, persons in charge and senior social care worker attended these meetings. These were being held virtually at the time of this

inspection. Operational team meetings also took place and the person in charge had easy access to senior management.

The provider sought to enable residents to live in a community environment that enabled them to live a meaningful life. This support was provided in partnership with residents' families. As outlined in its statement of purpose, the Willows use a 5 point star approach to care. Staff focus on; (a) understanding the individual, (b) communicating in the best possible manner, (c) meeting the expectations of the resident, (d) motivating the resident and (e) supporting the sensory perception of the residents. In the two years since its opening, the centre experienced a number of changes of staff including changes to key management staff. For example, since opening there had been four different named persons in charge and five different named persons participating in management. In addition, in the months preceding this inspection, there was a change of senior social care worker and other front line staff. Such changes was not conducive to implementing the approach to care that the provider outlined in their statement of purpose.

The statement of purpose set out the services provided which included amongst others, autism specific occupational therapy. However, at the time of this inspection the occupational therapist post was vacant. Recruitment for the position was ongoing. Inspectors were told if residents required occupational therapy it would be obtained either through the HSE or privately. There was a lack of clarity around how long a resident would be waiting for this therapy and if accessing privately, who was paying for the service. Given the sensory needs of the residents and it being stated that support with sensory perception was a key facet of the service, more robust clinical sensory provision arrangements were needed.

The staff training matrix indicated that staff had completed training in fire safety, safeguarding, medication management, manual handling, infection prevention and control, and food safety. New staff completed a core skills training week, a one day induction in the centre with the person in charge along with shadow shifts during the day and night. In addition, all new staff completed a six month probation period. In order to ensure staff were up to date with training, there was a traffic light system in place and the learning and development coordinator in the organisation circulated a quarterly report to all services advising of compliance. Formal staff supervision was provided by the person in charge every eight weeks.

There were a number of closed complaints made by staff on behalf of residents. These complaints were addressed and managed as per the complaints policy on a local level and protocols and risk assessments put in place for the residents involved. The person in charge was clear on the process of making a complaint and was the designated complaints officer for the centre. All complaints within the organisation are logged on a quarterly basis.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge of the designated centre.

The post of person in charge was full-time and the post holder had the required qualifications, skills and experience necessary to manage the centre.

Judgment: Compliant

Regulation 15: Staffing

Planned and actual rotas were in place and properly maintained. Staff supervision took place on a regular basis. Where required, regular relief staff were used in an effort to provide continuity of care to residents. However, there was a significant turnover of management and front line staff over the previous eighteen months which had impacted on resident care and their need for consistency. It also impacted on building a staff team and providing a consistent service to the residents in line with their care and support plans.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff training matrix indicated that staff had completed training in fire safety, safeguarding, medication management, manual handling, infection prevention and control, and food safety.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were in place. However, clarity was required around some of the governance, management and oversight processes.

These included:
* the decision making process and review around restraint use
* the process to access clinical sensory supports
* the status of the action plans from provider inspections/audits.

Judgment: Not compliant

Regulation 3: Statement of purpose

The information contained in the statement of purpose in relation to the level of therapeutic support did not match with what was actually happening in the centre. There were two main issues; the turnover of staff compromised the 5 point star approach which was a key facet of the model of care. The accessibility of clinical sensory occupational therapy support was unclear.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a clear complaints policy and an accessible version available to residents. There were no open complaints on the day of the inspection.

Judgment: Compliant

Quality and safety

Residents' safety and welfare was maintained by a good standard of care and support. However, as referenced earlier in this report, having a consistent staff team would improve how the needs of each resident could be met. In addition, clearer operational processes were needed around decisions taken to implement restrictions. Greater consideration was required as to how some decisions taken to ensure resident safety, impacted on their rights and dignity. Furthermore a clearer pathway was needed to ensure residents had access to therapy specialists such as occupational therapists, to support residents with complex sensory needs.

The nature of the residents needs required significant psychological support. The organisation had access to an assistant psychologist based in Ireland. The provider parent organisation also had support, if need be from its UK organisation. In addition, the person in charge informed inspectors that residents had access to psychiatry support from the Health Services Executive (HSE) community services.

In order to promote consistent care and support practices, there was the previously referenced document called, "Personal Quality Enhancer". This was a checklist of items for staff to reflect on, based on each resident's routine and specific needs. It was completed daily and monitored by the person in charge. There were visuals on the wall to support residents to understand their schedules and to make choices.

A behaviour support team was in place and the person in charge, along with the assistant psychologist, transition manager and area managers were part of this team. The team met monthly. Minutes of these meetings were viewed and while individual resident behaviour support needs were not discussed in detail at the

positive behaviour support team meetings, inspectors were informed that if a need for behaviour support was identified at this meeting, members of that group would provide the appropriate targeted assistance. Staff had received training in the area of positive behaviour support. The person in charge, along with five colleagues were trainers of the positive behaviour support programme. These five trainers in turn were reviewed each year to ensure consistency and appropriateness of their practice. This review was carried out by a team from the UK.

Behavioural support plans were a key component of the residents' care. These plans were in place. They were up to date and the documentation indicated they were primarily the work of the key worker. The centre's statement of purpose outlined that an occupational therapist and psychologist oversaw individual residents clinical needs. However, it was not clear what level of input these clinicians had in the individual behaviour support plans. Given the complex needs of the residents, evidence of such input would be expected to be clearly visible. Inspectors were informed by the area manager that occupational therapy was sourced privately as the need arose. The statement of purpose stated occupational therapists were part of the organisation's staffing cohort.

The person in charge spoke about a low arousal approach to managing behaviours and of her experience in managing such care needs. She was in the process of building a consistent team, as behaviours that challenged had been exacerbated by recent changes in staffing personnel.

Inspectors were informed of restrictions such as a stair gate, that had been in place and was subsequently removed. Inspectors were informed of one particular practice that did restrict residents entering their home and accessing home facilities. This occurred if a certain challenging behaviour arose for another resident. However, this was not listed as a possible restriction. Inspectors were informed this restriction had not been necessary since February 2021.

Minutes viewed of the positive support team meetings, did not show reviews of individual restrictive practices. Inspectors were informed of plans to hold specific restrictive practice review meetings but these had not yet commenced. Overall, the decision making process in place around the use, review or removal of a restrictive measure was inadequate.

Inspectors saw from the complaints documented, that staff advocated on residents' behalf. The complaints referred to one occasion in January 2021 and a second similar instance in February 2021, when residents movements and access to their house were restricted. On one occasion, residents waited in a car for one hour and 20 minutes during which time incontinence occurred. Another time, residents were confined to the kitchen resulting in two residents not being able to use the toilet facilities and becoming incontinent. In one instance, the manner in which personal assistance was given compromised privacy and dignity.

An organisational risk register was available for the inspectors to view on the day of the inspection which outlined high level risks. There was an incident and accident register. At centre level, there was a safety statement, a risk management policy

and a number of identified risks with corresponding risk assessments. Individual risk assessments for residents were also completed.

Regulation 17: Premises

The premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. It was of sound construction, kept in a good state of repair and decorated in a homely manner

Judgment: Compliant

Regulation 26: Risk management procedures

There was a safety statement and risk management policy was in place and a number of identified risks with corresponding risk assessments. Individual risk assessments for residents were also completed. A health and safety committee was in place and the person in charge was a member of this committee.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had produced guidelines on the prevention and management of COVID-19. The facilities available, such as warm water, mixer taps, paper towels and pedal operated waste bins, all facilitated good infection prevention control. Hand gels and sanitisers were available throughout. Staff wore masks in situations where a two meter distance could not always be maintained. Cleaning schedules were in place. Staff and visitors to the house had temperature checks taken and recorded on arrival at the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

It was evident from speaking with the person in charge that an individualised approach had been taken to assessing each resident's needs. Overall, care plans were written in a respectful way.

Judgment: Compliant

Regulation 6: Health care

Overall, residents' health care needs were well attended to. Residents had access to medical review, including psychiatry as the need arose. There was a lack of clarity on the availability and access to health and social care professionals to meet the healthcare needs of residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Behaviour support plans were drawn up by key workers. Clinical input, oversight and review of the suitability and effectiveness of behaviour support plans was not evident.

Judgment: Not compliant

Regulation 8: Protection

Staff had received training in safeguarding. A finance team carried out an audit of petty cash and residents' money management four times each year.

Judgment: Compliant

Regulation 9: Residents' rights

Staff worked with residents to inform them of their rights and advocated on their behalf. However, residents were impacted by the behaviour of others. Two residents had to wait in a car for an hour and 20 minutes due to a crisis in the house. This resulted in incontinence for a resident. A similar situation arose in the kitchen of the house whereby access to toilets was not possible and incontinence resulted. Attending to this personal and intimate care had to be carried out in the kitchen.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for The Willows OSV-0005792

Inspection ID: MON-0031041

Date of inspection: 13/04/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 5 Point star and autism awareness has resumed since April, all staff who commenced in employment and did not attend this training due to the pandemic will be booked in for these trainings, this has now returned to core skills week for new starters. This includes permanent and relief staff.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Safeguarding internal training for all Team leaders- Title of training: Building a culture of safeguarding - Emphasis on the restriction process to be communicated to teams and the overly restrictive practice as a safeguarding concern • Designated Officer to attend team meeting to discuss restrictions/restraint use and overly restrictive practice as a safeguarding concern • Designated Officer training for Team Leads of services • *Training of: A Human Rights-based Approach for Health and Social Care Services, Health Information and Standards Directorate, HIQA to be rolled out * (This to be scheduled on the roster for staff completion upon return of access to HSElanD; one module per month to be completed) • Any decision to introduce a restrictive practice to be in consultation with a member of the Practice Support Team (PST). • Restrictions will be reviewed quarterly by the Practice Support Team. • Practice Support Team to update the terms of reference to say this is a core part of the PST.	

• Clarity of the process to access clinical supports to be outlined in SOP.

• Provider inspection/audits to include sign and date for individual actions, T/L /SSCW to sign off on each section once complete and actions have been evidenced. Auditor to review the completed actions in the service prior to signing as completed.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Therapeutic input will be amended on the statement of purpose to clarify the current referrals process to remove the internal access to O/T, include the referral process for external O/T through the HSE or privately where the wait is deemed to be too long.

5 Point star and autism awareness has resumed since April, all staff who commenced in employment and did not attend this training due to the pandemic will be booked in for these trainings, this has now returned to core skills week for new starters. This includes permanent and relief staff.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Therapeutic input will be amended on the statement of purpose to clarify the current referrals process to remove the internal access to O/T, include the referral process for external O/T through the HSE or privately where the wait is deemed to be too long.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Where assessment of needs has outlined clinical input for PBS Plans this will be clearly

stated on the PBSP.
• Team Leader (PBS trainer) to oversee PBSP's in place and when any changes occur.
• Suitability and effectiveness of PBSP's will be documented through incident reporting and review monthly.
• Review of assessment of needs at annual Future Planning Meeting for update of the need for clinical input.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Further Safeguarding training for all Team leaders – Building a culture of safeguarding - Emphasis on the restriction process to be communicated to teams and the overly restrictive practice as a safeguarding concern
• Designated Officer training for Team Leads of services
• *Training to be rolled out of: A Human Rights-based Approach for Health and Social Care Services, Health Information and Standards Directorate, HIQA (This to be scheduled on the roster for staff completion upon return of access to HSElanD; one module per month to be completed) *
• Meeting to take place between Team Leader and staff members to reflect on occurrences and plan for any future occurrence of behaviour of concern that does not compromise dignity of any service user or impact on rights.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	13/07/2021
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	Yellow	13/07/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set	Substantially Compliant	Yellow	13/07/2021

	out in Schedule 1.			
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	13/07/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	13/07/2021
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	13/07/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or	Not Compliant	Yellow	13/07/2021

	environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	13/07/2021