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:	Rose Lodge Residential Care Service
Name of provider:	Communicare Agency Ltd
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	21 May 2024
Centre ID:	OSV-0008627
Fieldwork ID:	MON-0041600

About the designated centre

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

Rose Lodge is a residential care service providing residential care for adults with mild to moderate intellectual disability, physical, sensory and medical challenges. A maximum of four residents over the age of 18 years are accommodated. The premises is a spacious four bedroom bungalow on its own generous site located midway between two well-serviced towns. Transport suited to the needs of the residents is provided. Each resident is provided with their own bedroom three of which have ensuite sanitary facilities. An additional bathroom is provided and the residents share communal areas that include an open plan kitchen and dining area and two living rooms. The design and layout of the house supports accessibility. Day-to-day management and oversight of the service is delegated to the person in charge with support from a team leader and the wider management team. The house is staffed at all times and there are a minimum of two staff members on duty by day and by night. The night time staffing arrangement is a staff member on waking duty and a staff member on sleepover duty.

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 (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 21 May 2024	09:45hrs to 17:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to monitor the provider's compliance with the regulations and standards. This was a relatively new service that was registered by the Chief Inspector of Social Services in September 2023. This inspection found evidence of good practice and compliance with the regulations. However, improvements were also needed. For example, improvement was needed to ensure that the staff team had the knowledge and skill-set required to understand and respond to behaviour that was challenging. Improvement was also needed so that residents had consistent and timely access to services provided by allied health professionals.

The designated centre was a single-storey property located on it's own spacious site in a rural but populated area. Two vehicles were available to take residents to a variety of different locations and services. The house was well maintained and was visibly clean throughout. Four residents lived in the centre. Each resident was provided with their own bedroom and three of these bedrooms had ensuite sanitary facilities. An additional bathroom was conveniently located to the bedroom that did not have an ensuite facility. The design and layout of the house supported accessibility. For example, the kitchen and dining area was open plan with good turning space for wheelchair users. A second living space was available to residents if for example, they wished to receive visitors in a space other than their bedroom. There were no restrictions on visits. The person in charge described how residents were consulted with and their wishes were established when visitors arrived to the house. Externally, level surfaces supported accessibility and ample provision was made for car-parking. The grounds were well maintained.

When the inspector arrived at the centre one resident was present. Of the remaining three residents one resident was on holiday with family, one resident was on weekend leave with family and, one resident was attending their off-site day-service. Two residents returned to the service before the inspector had left so the inspector had the opportunity to meet with three of the four residents living in the centre. The inspection was facilitated by the person in charge. The inspector also had the opportunity to meet with the team leader, a staff member on duty on the day of inspection and, to observe the general routine of the house and the support provided.

Staff were noted to be attentive to the needs of the resident who spent the day in the house. The resident was, over the course of the day, offered meals and refreshments, the opportunity to get up and to return to bed as they wished. The inspector did note however that between these regular checks the resident did call-out to seek staff assistance. Staff did hear the resident and they did respond promptly. The resident told the inspector that they previously had a staff call-bell but it was no longer available to them.

The resident who was happy to speak with the inspector was complementary of the

staff team and the support they received. The resident told the inspector that all of the residents got on fine together. The resident did express concern about their lack of access to physiotherapy which they believed would be of benefit to their recovery. The resident said that they had made a decision to seek and pay for a private service. Assessment and input from allied health professionals had been completed prior to and following admission to the service. The person in charge confirmed however that physiotherapy programmes that had been in place following admission had ceased. The person in charge reported that they continued to liaise with relevant persons but, it was challenging to get access for residents to community based services. The person in charge had submitted new referrals on behalf of two residents. Prior to the conclusion of this inspection the person in charge advised the inspector that further reviews, including physiotherapy review were to be completed in the coming week.

There was evidence that residents were consulted with. For example, as mentioned above, during this inspection, the staff members on duty engaged and consulted with the resident in the house. Regular house meetings were held. The minutes of the house meetings reviewed showed that matters such as preparing residents for a new admission, how to make a complaint, how to exercise their religious and civil rights if they wished and, the support they would receive in this regard were discussed with residents. However, other records seen such as the daily care and support records indicated that particular choices and preferences expressed by a resident were not listened to. This impacted on the quality of the service provided.

Staffing levels were generally adequate to support individual choices and routines. However, this required review following a recent change in resident needs.

Overall, the inspector found that the personal plan reviewed was not sufficient to inform and guide the care and support provided each day. The personal plan reviewed was fragmented and did not comprehensively address all of the resident's assessed needs and changes in these needs such as in access to physiotherapy and exercise programmes. The plan did not provide clear and sufficient guidance for staff which meant that there was evidence in practice of practice that was not outlined in the plan. For example, in relation to personal and intimate care needs. In addition, much improvement was needed in the development of an evidence based plan to support a resident who demonstrated at times, behaviour that challenged the staff team. A comprehensive programme of education and training for staff was needed in conjunction with the development of the plan.

All of the residents spoken with were complementary of the meals provided. The inspector sat and chatted with two residents as they waited for their evening meal. Staff were preparing the meal in the adjoining kitchen and the aroma from the cooking was appealing. Residents had expressed different meal choices and these choices were facilitated. There was a general discussion between the inspector, a resident and a family member of the importance of the regular visits to home and family that the resident enjoyed. The resident smiled and laughed as it was described to the inspector how the family dog, who was no longer a puppy still tried to climb up on the resident's lap.

The other resident said that they loved going to their day service Monday to Friday but also liked living in the house. The resident discussed their love of traditional music and said that they loved playing their keyboard for their peers and the staff.

In summary, this was a relatively new service. The provider had management arrangements and quality assurance systems for monitoring the appropriateness, quality and safety of the service. However, based on these inspection findings and the improvements that were identified as needed, particularly in relation to the arrangements for understanding and responding to behaviour that challenged, improvement was needed in both oversight and in the robustness of actions taken to improve the service.

The next two sections of this report will 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

The management structure was clear as were individual roles and responsibilities. The centre presented as adequately resourced. The provider had quality assurance systems. The provider was collecting information about the quality and safety of the service and, quality improvement plans were issued and progressed. However, based on these inspection findings management and oversight of the centre was not robustly ensuring that the required arrangements were in place to underpin the appropriateness and quality of the service.

The day-to-day management and oversight of the service was delegated to the person in charge. The person in charge worked fulltime and was based in the house. The person in charge confirmed they had shadowed the previous person in charge as part of their induction in early 2024. The person in charge said that they had access as needed and good support from the senior management team. The person in charge formally met each week with senior managers who were also reported to be regularly present in the house.

The person in charge was supported by a team leader who had delegated duties and responsibilities. These included the weekly check of areas such as the completion of daily handovers between staff. The person in charge also completed key performance indicators that were returned to senior management such as of incidents that had occurred and any complaints that had been received.

The provider had in February 2024 completed a review of the quality and safety of the service. Additional systems of quality assurance included medicines management and infection prevention and control audits. These reviews did identify deficits and, corrective plans were issued and progressed. For example, in relation to fire safety.

The person in charge maintained the staff duty rota and confirmed that while the recruitment of staff was challenging there were no staff vacancies and no concerning turnover of staff. There were two staff members on duty by day and by night excluding the person in charge. The night-time staffing arrangement was one staff member on waking duty and one staff member on sleepover duty. However, the needs of one resident had recently changed and two staff members were now required to ensure safe assistance and transfers. There was some evidence that this had impacted on the routines and choices of another resident and this required review by the provider.

A record was maintained of the training completed by staff. Some training was awaiting completion such as in fire safety and the management of medicines. This training was scheduled and the person in charge could describe to the inspector the controls in place to manage risk that could arise until this training was completed. For example, staff were familiarised on induction with the centres fire safety arrangements, they participated with other staff in the daily checks of fire safety systems and, were always on-duty with a staff member who had completed fire safety and medicines management training.

Additional training for staff was needed to support them to develop the knowledge and skills to respond to behaviour that challenged.

Records were in place of regular staff team meetings convened by the person in charge. The person in charge confirmed there were systems in place for the formal supervision of all grades of staff.

Regulation 14: Persons in charge

The post of person in charge was full-time. The person in charge had the necessary experience and qualifications to carry out the role. The person in charge was based in the centre and was well known to staff and residents. The person in charge was knowledgeable regarding their statutory responsibilities and the support needs of the residents.

Judgment: Compliant

Regulation 15: Staffing

There was a minimum of two front-line staff members on duty by day and by night. The person in charge was also available as needed during the week. There was evidence in records seen and in discussion with a resident that staffing levels had recently impacted on the established routine and the requests of a resident. For example, a request to attend mass and a request to go outside to enjoy some sunshine. This appeared to have arisen as one resident had been recently assessed

as needing two staff members to ensure safe transfers and assistance. This meant if there were two staff members on duty it was not safe for one staff member to be in the house if the other staff member was off-site supporting another resident. This two-to-one staffing requirement and the capacity of the current staffing levels to meet the needs of all four residents required review by the provider.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was, based on records seen and confirmed by the person in charge, outstanding staff training in fire safety and medicines management. The person in charge was aware of this and confirmed that this training was booked. The person in charge outlined the controls in place to manage risk that could arise until this training was completed. Additional training completed by the staff team included a range of infection prevention and control training and basic life support. Positive behavioural support training for staff was needed. This is addressed in Regulation 7: Positive behavioural support.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The provider had systems of quality assurance for monitoring the quality and safety of the service. These systems did identify areas where improvement was required and quality improvement plans were progressed. However, based on these inspection findings there was a requirement for more robust oversight and more robust corrective actions. This was required to ensure that the care and support provided to residents was at all times evidence based, appropriate to their needs and ensured residents received the best possible quality service. For example, the most recent internal review completed in February 2024 had identified the need for a positive behaviour support plan. A plan was put in place but it did not, based on these inspection findings result in good evidence based practice.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

A transition plan seen by the inspector indicated that a resident and a family

member were offered the opportunity to visit the centre prior to admission. The provider had agreed in writing with the resident a contract for the provision of services. The contract included the details of any fees to be paid.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on the records seen in the centre such as the records of accidents and incidents that had occurred, there was no evidence that incidents that should be notified to the Chief Inspector of Social Services had not been notified. For example, there was no evidence of any injury sustained by a resident that required immediate medical intervention.

Judgment: Compliant

Regulation 34: Complaints procedure

Information on how to complain was prominently displayed. How to complain was discussed with residents for example at the house meetings. The person in charge said that residents were good to voice concerns. The inspector reviewed records of matters that had been raised by residents. For example, an occasion where staff had omitted to provide a packed lunch and a request for raised flower beds. The person in charge documented the actions they took to resolve these issues and, whether the residents were satisfied or not. For example, the request for raised flower beds was stated to be partially resolved as their delivery was awaited.

Judgment: Compliant

Quality and safety

It was evident that the provider strived to provide residents with a safe, quality service and this objective was met on many levels. For example, residents were provided with a safe and comfortable home, had opportunity to maintain friendships and relationships and, to access amenities and services that they enjoyed. However, as discussed in the opening section of this report, improvement was needed such as in personal planning and in the arrangements for supporting residents who exhibited behaviour that challenged.

The care and support observed was timely and attentive to the needs of the

residents. Residents appeared to be comfortable in their environment and with staff supporting them. However, the inspector was not assured that the personal plan reviewed by the inspector actually informed and guided the care and support that was provided to the resident including the provision of personal and intimate care. The plan did not comprehensively address the care and support needs of the resident or, a clear pathway as to how the resident's personal goals and objectives were progressed or, if not progressed, why not.

Based on the recommendations of an internal audit the person in charge had put a positive behavioural support plan in place. Succinct guidance was provided for staff on matters that could potentially act as a trigger for behaviours and how staff were to respond. However, based on narrative care records seen and discussion with the person in charge further timely action by the provider was needed to improve staff understanding of and staff responses to behaviour that challenged them. The improvements needed included analysis of the behaviours, when they occurred, why they possibly occurred and how they were responded to. A programme of education and training for staff on how to implement therapeutic responses was required.

The person in charge reported that there were no physical or environmental restrictions in use such as bedrails. Staff had completed training on restrictive practices. However, based on these inspection findings better awareness of practice that constituted a restriction on a resident's rights was needed. Residents were consulted with and provided with information for example in relation to the providers safeguarding procedures, how to access advocacy and voting. All residents were registered to vote and one resident was reported to be actively interested in exercising their vote. The person in charge said they would be supported to do this. Residents did have reasonable choice and control. For example, one resident did not wish to have a key-worker and, based on records seen, residents themselves had decided not to continue wheelchair tennis. However, it was also evident from records seen that a resident's wishes were not always respected and facilitated and the resident did not have choice and control over all decisions about their care and support. For example, where staff continued to direct the resident to comply with a particular care intervention despite the resident's expressed wishes and protestations. In addition, the provider needed to review resident access to, where appropriate to their needs, a staff call-bell.

The person in charge was aware of challenges to the provision of the best possible quality service such as the skills-set for responding to behaviour that challenged. Challenges had also arisen to ensuring residents had access to the allied healthcare services so that they enjoyed the best possible health and wellbeing outcomes. This was raised by a resident the inspector spoke with and confirmed by the person in charge. The person in charge had submitted referrals and was liaising on behalf of residents with the providers funding body.

Medicines were supplied by a local pharmacist. Residents were supported to participate in their medicines management plan. There were systems for auditing medicines management practices and for recording and responding to errors that occurred. However, the storage of medicines required review as there was no

medicines specific storage.

The inspector saw that fire safety arrangements such as fire resistant doors with self-closing devices, emergency lighting and a fire detection and alarm system were all provided. Staff completed daily and weekly checks of these systems including a test of the fire detection and alarm system. Checks by external contractors were also completed. However, all records in relation to these external checks were not available in the centre on the day of inspection.

Regulation 11: Visits

The person in charge confirmed that there were no specific visiting times and visits were facilitated based on the expressed wishes of each resident. There was a room other than the residents bedroom that could be used for receiving visitors. On the day of inspection a visitor sat at the dining table with their family member and a great inclusive discussion developed between the visitor and another resident about the skills needed to play a particular musical instrument.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were given choice and opportunities to access and enjoy a range of services and amenities. One resident was supported following their admission to continue to attend their day service. The resident told the inspector that they loved going there. Two residents attended another day service once a week for persons with similar needs. Residents enjoyed meeting up with friends and doing routine day-to-day things such as going shopping, having coffee or going to the pub to watch a match. One resident went swimming once a week and also completed a weekly course on information technology. Residents had enjoyed a programme of tennis specifically for wheelchair users. As appropriate to their individual circumstances residents were supported to maintain contact with home and family.

Judgment: Compliant

Regulation 17: Premises

The house was designed and laid out to meet the assessed needs of the residents. The design of the house promoted accessibility. The house was found to be well maintained and visibly clean. Communal areas were pleasantly furnished and decorated. Specialised equipment including beds and aids to support standing and

transfers was provided.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents told the inspector that they enjoyed the meals that were provided. The inspector saw that residents were offered choice and the records of the meals provided reflected good choice and variety.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the identification, assessment, management and on-going review of risk. Each resident had a suite of risk assessments and a risk management plan. Incidents were reviewed as they occurred by the person in charge and data and feedback was provided to the management team. Incidents were discussed with staff at the staff team meetings and individually with staff if support was required following an incident.

There was a centralised function for ensuring vehicles used to transport residents were for example taxed and insured. There were no local formal procedures for completing regular visual vehicle checks. For example, checks to ensure any required safety equipment was in the car. The provider should consider the implementation of such checks.

Judgment: Compliant

Regulation 28: Fire precautions

There were fire safety management systems in place. For example, each resident had a personal emergency evacuation plan (PEEP). Regular simulated drills in which residents and staff participated were completed. The drill reports indicated that residents could be effectively evacuated. The design of the house included the provision of doors from a bedroom that supported the evacuation procedure. There was evidence that fire safety equipment was inspected and tested. For example, the label on fire-fighting equipment stated that they had been inspected and tested in June 2023 and, the fire detection and alarm panel and the emergency lighting were inspected and tested in February 2024. However, the actual certificate for the

inspection and testing of the fire-fighting equipment was not in the centre nor was there evidence to support the inspection and testing of the fire detection and alarm system between August 2023 and February 2024.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

While medicines were stored in a locked cupboard they were not stored in a cupboard designated solely for that purpose. Other items including personal plans were also stored in the cupboard. This meant that staff and not just staff involved in the management of medicines had access to the cupboard and to the medicines. As outlined in guidance issued by HIQA is it not good practice to have items other than medicines and their associated records stored in the medicines cupboard.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plan reviewed by the inspector was fragmented and did not comprehensively set out the care and support to be provided in response to the resident's assessed needs, wishes and expressed preferences. This did not ensure consistency of support or the evidence base of the support provided. For example, the inspector did not find any evidence in the plan of the need for the personal care intervention that staff wanted a resident to use and which the resident very clearly did not want. Plans for supporting physical and health care needs lacked robustness and did not reflect for example, the healthcare needs referred to in the risk management plan such as high blood pressure and high cholesterol levels. The plan did not for refer to the loss of physiotherapy input. The plan did set out the resident's personal goals and objectives and how these were decided based on discussion with the resident. However, the progress of these including any obstacles to their progression was poorly evidenced.

Judgment: Substantially compliant

Regulation 6: Health care

The person in charge sought to ensure that residents had access to the services that they needed in response to their assessed needs and changes in these needs. Prior to admission and following transition to this service, reviews and assessments had

been completed by allied health professionals to inform the suitability and appropriateness of the care and support to be provided. However, a resident spoken with spoke of how they had decided to access and pay for private physiotherapy as they were told there was a two year waiting list for the public service. The resident described how prior to their admission they stood and walked a little distance with support from a physiotherapist and equipment such as parallel bars. The resident said that following admission they had been provided with a motorised movement device but they no longer had it. The person in charge confirmed that the equipment had been reclaimed as it had been provided by community based services only as part of a twelve week publicly funded programme. The person in charge said that it was currently challenging to get access for residents to allied health services and, they were making consistent efforts in this regard. The person in charge had, prior to this inspection and based on discussions they had with relevant stakeholders, submitted new referrals for two residents. The person in charge had submitted referrals seeking for example further physiotherapy, occupational therapy and speech and language therapy from community based services. Prior to the conclusion of this inspection the person in charge told the inspector that they had received confirmation that the requested speech and language, physiotherapy and occupational therapy reviews were all scheduled for the following week.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Based on these inspection findings adequate and appropriate arrangements were not in place for responding to behaviour that challenged and for supporting residents in an evidence based way to manage their behaviour. The person in charge confirmed that staff had completed training in intervention and escalation techniques but said staff working in the centre did not have experience of working with residents who exhibited behaviour that challenged. The person in charge said that a referral had been sent for review by psychology. There was no active psychiatry input. Following the most recent internal provider review that person in charge had put guidance in place in March 2024 for staff setting out possible triggers for behaviour and the most appropriate way for staff to respond. For example, the guidance stated that the resident wished to make their own decisions and did not like repeat requests or queries from staff. However, it was evident from records seen such as incident records and narrative care notes that this guidance was not consistently followed and behaviour was at times exhibited in response to staff interactions. Generally this was where a staff member wanted the resident to do something that the resident did not want to do, for example in relation to personal and intimate care needs. Some documented staff responses were not evidence based, therapeutic, respectful or person centred. Better awareness was needed of how such practice potentially was a restriction on residents rights including a resident's right to consent to support or not and decisions about their

support and care.

In addition, the person in charge confirmed that the staff call-bells had been removed from residents' bedrooms. A resident told the inspector that he had to call out or use his mobile phone at times to contact staff. The inspector heard the resident to call out. In narrative notes reviewed but not pertaining to the day of inspection the resident calling for staff support was described by a staff member as shouting and the resident was advised that their shouting (in the absence of access to a call-bell) was disturbing the other residents.There was a clear sense of exasperation in some records created by staff with the use of exclamation marks and evident disquiet at the frequency the resident was calling for assistance.

Judgment: Not compliant

Regulation 8: Protection

The training records indicated that staff had completed safeguarding training. Safeguarding had been discussed with residents at a recent house meeting and a range of safeguarding material was available to residents. Safeguarding was discussed at the staff team meetings and the designated safeguarding officers within the organisation were available as needed.

Judgment: 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially 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

Compliance Plan for Rose Lodge Residential Care Service OSV-0008627

Inspection ID: MON-0041600

Date of inspection: 21/05/2024

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: Staffing needs analysis completed by PIC by outlining staff levels needed in the service to address ongoing needs of the Service Users. OT review took place on the 11th of June to assess and review the changing need is the service users. While there was a need to temporarily increase the staffing ratio while awaiting OT and physio assessment, Service User's status reverted now to assistance of 1. The service users' appointments, activities and outings are a standing agenda topic for the residents meeting and the one to one meetings. Staffing levels are assigned in accordance with the needs and in consultation with the Service Users. PIC endeavors to facilitate all the activities that are planned. An ongoing recruitment campaign to employ relief staff to support service provision is in place.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Management will carry out a high level indepth review of the Positive Behavioural Support Plan. The external PETMA training facilitator will be consulted regarding the best practice approach to behaviours of concern presented by a Service User. An additional training to address the behavioural concerns will be provided to all staff in the service. The training	

is tailored to guide the best pratice when supporting people with Aquired Brain Injury and will take place on 26th and 29th of July.

Enhanced daily supervision of service provision will be implemented and documented accordingly in the weekly audits. The PIC and Team Leader will be responsible for conducting these.

The key worker meetings with the Service Users take place monthly or sooner as required to ensure their individualised support plans are reflective of their current and ongoing needs and updated and communicated to all staff in a timely manner.
The PIC is responsible for governing this practice and it will be evidence by her regular documentation reviews, discussions with service Users, staff supervisions and regular audits.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The certificate for Fire Equipment check completed in July 2023 has been located and shared with HIQA inspector on 31/05/2024
A Certificate for Fire equipment obtained and filed in Safety Records

A CMR Fire Security Group will conduct the fire checks as per schedule by the end of June.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Additional locked storage will be obtained for the office to facilitate the Service Users' documents not relevant to their medications. The locked storage cabinet ordered 1/6/24

Only staff who have completed their Safe Administration of Medications will have access to the medication cabinet.

The training related risk assessment has been updated to reflect the new measures in place.
All Staff informed of new arrangements as of 04/06/24

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 full review of all Service Users support plans, to include positive behaviour support plans is ongoing and will be completed by 31/07/24.
The review will result in Service Users Support Plans to be more comprehensive and reflective of their ongoing needs, wishes, goals, obstacles and achievements. Each key worker is responsible for updating these support plans in conjunction with the Service User and the PIC is responsible to review and monitor the support plans and ensure that the actions are implemented in timely manner.
Person Centred Planning meetings are scheduled with all residents to review their Care/Support plans and Action plans.

The intervention mentioned in the report was stopped immediately. Senior management investigates the circumstances in which staff implemented it on the particular shift.
At the Team meeting on 28th of May PIC discussed:
- the intervention that was utilised on the particular day,
- personal care support plan for the service user,
- consent policy and
- FREDA principles adhered to for all care and support interventions.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Community HSE allied health services have and continue to been involved in the service users' care planning as part of transition and admission to our Residential care Service. The allied health services, to include Occupational Therapist, Physiotherapist and Speech and language Therapist, have visited the service on several occasions as requested by PIC via referral to assess and provide guidance on the individual support plans.

Recently the PIC had contacted the Physiotherapist and Occupational Therapist to again review two of the Service Users, and at this stage the response was that there was a long waiting list for the community services.
It was then explained to the Physiotherapist and Occupational Therapist of the changes in the Service Users status, and concerns in relation to their current needs, and at this stage the they advised to send a new referral form for both Service Users and that they would prortise them. This had been completed and the Speech and Language therapist

visited a Service User in the Centre on 28th of May and Occupational Therapy review is scheduled for 11th of June. Their guidance will inform Care/Support Plans.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A full review of the Staff Skill mix and Training analysis will be completed in conjunction with HR department by the 30th of June.
The outcome of the review will feed into the Company Development strategy and an internal and external training to support Positive Behavioural Support Plans.
The external training will take place on 26th and 29th of July and will be tailored for the purpose of specific needs of the Service Users in the Rose Lodge Residential Care Service.
External training provider sourced and scheduled to deliver additional staff training on Behaviours that Challenge with emphasis on Acquired Brain Injury. The training uses the PETMA (Professional Ethical Therapeutic Approach), and a human rights based approach to support residents when distressed. The training will be provided on the 26th and 29th of July.

External Advocacy Services will visit the service and service Users in July 2024 and also provide workshop on Advocacy for Staff.

All staff to have a comprehensive understanding of best practice in relation to the FREDA Principles, Rights Based Approach and Consent.
All staff assigned to complete / refresh their training on the following:
- Introduction to Human rights in Health and social care,
- Roles of Good Communication in upholding Human Rights,
- Putting People at the centre of Decision making,
- Putting National Standards into practice and
- Consent.

At the team meetings on 28/05/24, 04/06/24,10/06/24 Staff review/refresher of the following policies:
- Safeguarding,
- Providing Intimate and Personal Care,
- Respecting Privacy and Dignity of Service Users,
- Management of Behaviors of Concern

The use of call bell in the house will be discussed at the residents meeting on 21/06/24 to include a discussion of the use of Call Bell in the service. All residents in agreement that a resident who wish to have a call will be facilitated.

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	30/06/2024
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.	Substantially Compliant	Yellow	30/07/2024
Regulation 28(1)	The registered provider shall ensure that	Substantially Compliant	Yellow	30/06/2024

	effective fire safety management systems are in place.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	30/06/2024
Regulation 05(6)(b)	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 be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	31/07/2024
Regulation	The	Substantially	Yellow	31/07/2024

05(7)(c)	recommendations arising out of a 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.	Compliant		
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	11/06/2024
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.	Not Compliant	Orange	29/07/2024
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,	Not Compliant	Orange	29/07/2024

	and are reviewed as part of the personal planning process.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	29/07/2024