Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Grangemore Rise
Name of provider:	St. Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	25 April 2019
Centre ID:	OSV-0002341
Fieldwork ID:	MON-0026261

About the designated centre

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

The designated centre is located in North County Dublin. It is operated by St Michael's House and provides services to seven adults with an intellectual disability who have varied support requirements over the age of 18. The designated centre consists of a house and adjoining apartment. The house is a two storey building and is home to five residents (one on a part time basis) and consists of a storage room, toilet, utility room, kitchen, dining room/living room, two bathrooms, two offices and six individual bedrooms. The adjoining apartment is home to one resident and consists of a kitchen, living/dining room, utility room, staff room, bathroom and bedroom. The designated centre is located close to local shops and transport links. The centre is staffed by a person in charge, nurses, social care workers and care assistants.

The following information outlines some additional data on this centre.

Current registration end date:	12/03/2020
Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
25 April 2019	09:00hrs to 17:00hrs	Conan O'Hara	Lead
25 April 2019	09:00hrs to 17:00hrs	Amy McGrath	Support

Views of people who use the service

The inspectors had the opportunity to meet with four of the six residents during the inspection. One resident was away on the day of the inspection and another was out on a community based activity. Some residents communicated their thoughts and opinions verbally while others used non verbal methods to communicate. Some residents did not wish to speak with inspectors on the day of the inspection.

One of the residents spoken with told inspectors that they were happy living in their home, and that they liked the staff who worked there. Throughout the course of the inspection, residents were observed by inspectors as they engaged in their daily activities. Residents communicated their needs and preferences to staff throughout the day, and appeared comfortable making decisions about their support. Other residents who engaged with inspectors indicated that they were comfortable in their home, and that they particularly liked their own bedrooms.

Inspectors observed that residents had visitors throughout the day, and engaged in activities outside of the centre.

Positive interactions were observed between the staff team and the residents, and residents presenting needs were responded to in a prompt and caring manner.

Capacity and capability

This unannounced inspection was carried out to follow up on the compliance plan submitted by the provider in response to the significant levels of non-compliance identified at an inspection carried out in December 2018. Since the last inspection one resident had been discharged from this designated centre to another service.

Inspectors found that the provider had failed to demonstrate they had the capacity and capability to effectively govern the service to ensure that safe and quality care and support was delivered to residents. Furthermore, inspectors found that the provider had not adequately completed the actions agreed in the compliance plan submitted in response to the most recent inspection, in order to operate in compliance with the regulations. This centre had also been identified by the provider themselves, in January 2019, as a being a centre of concern with further areas for improvement identified in a their most recent six month annual review completed February 2019. This further compounded the findings of poor governance, oversight and surveillance of the service.

Although there was a clearly defined management structure in

place, inspectors found that this system was not utilised effectively, and found that a number of significant issues had not escalated appropriately, or had been followed up on. The inspectors found that while the provider had met their regulatory requirement of carrying out unannounced six monthly reviews and an annual review for 2018, the oversight of the service was inadequate and did not ensure a safe and effective service. For example, issues identified through the provider's six-monthly unannounced visits had not been acted upon. Furthermore, other assurance mechanisms, such as local audits and reviews were found not to have been completed, and as such, concerns relating to the quality and safety of the service were not escalated through the appropriate channels or responded to as required. This was further compounded by the fact that the issues raised at the last inspection in December 2018 remained outstanding, and as detailed throughout the report, significant levels of non-compliance remained and continued to be identified.

The inspectors found that while the staff team strived to provide a person centred service, the provider failed to demonstrate and ensure the oversight mechanisms were adequate in monitoring the effective delivery of quality care. The provider's failure to address these areas of non compliance, as discussed further in the report, were impacting on key areas of residents' lives such as upholding their rights and protection.

The inspectors reviewed a sample of the roster and found that there was sufficient numbers of staff to meet the assessed needs of residents. However, at the time of the inspection there was a 2.5 whole time equivalent vacancy. The inspectors found that there was an over reliance on relief and agency staff given the assessed needs of the residents. The inspectors acknowledge that the provider was in the process of actively recruiting to fill these vacancies and had made some arrangements to ensure continuity of staffing. In addition, following an assessment of need, the centre was in the process of transitioning from a nurse led service to a social care led service.

The inspectors reviewed the training plan for 2019. On the day of inspection, there was evidence that some training had been scheduled however not all staff had received up to date training in areas determined by the provider to be mandatory, including positive behaviour support for two members of staff, and refresher safeguarding training for one staff member.

The centre's statement of purpose did not accurately contain all of the information as required by Schedule 1 of the regulations.

The inspectors reviewed a sample of incidents and found that the Office of the Chief Inspector was notified of incidents as required under Regulation 31. However, the absence of the person in charge for a period greater than 28 days was not notified to the Office of the Chief Inspector as required by Regulation 32.

There were systems in place to manage complaints and the centre maintained a complaints log. A review of the complaints log found that not all complaints were managed in line with the provider's policy. Some complaints pertained to issues

raised in previous complaints, and there was no record available of the response to the complainant, or if the complainant was satisfied with how the complaint was managed. While the provider had an identified complaints officer, it was not evident that complaints management was being effectively overseen.

Overall, given the cumulative and ongoing levels of non-compliance identified on inspection, inspectors were not assured that there were effective governance and management arrangements in place, to monitor the delivery of safe care to residents.

Regulation 15: Staffing

The provider failed to complete the action to address this area of non compliance as per their action plan submitted to the Office of the Chief Inspector 22 January 2019; although there were sufficient numbers of staff to meet the assessed needs of residents, it remained that there was an over reliance on relief and agency staff given the assessed needs of the residents.

The provider had previously stated that this would be addressed by January 2019.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider failed to complete this previously identified action to address this area of non compliance as per their action plan submitted to the Office of the Chief Inspector 22 January 2019; not all of the staff had up to date mandatory training.

The provider had previously stated that this would be addressed by January 2019.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose did not accurately contain all of the information as required by Schedule 1 of the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspectors reviewed a sample of incidents and found that the Office of the Chief Inspector was notified as required under Regulation 31.

Judgment: Compliant

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

The absence of the person in charge for a period greater than 28 days was not notified to the Office of the Chief Inspector as required by Regulation 32.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider failed to complete this previously identified action to address this area of non compliance as per their action plan submitted to the Office of the Chief Inspector 22 January 2019; it was not evident from reviewing the complaints log that all complaints were managed in line with the provider's policy.

This was also identified at the previous inspection and the compliance plan stated that this would be addressed by January 2019.

Judgment: Not compliant

Regulation 23: Governance and management

The provider failed to complete this previously identified action to address this area of non compliance as per their action plan submitted to the Office of the Chief Inspector 22 January 2019; it remained that the governance and management arrangements were not effectively ensuring a safe and effective service was delivered to residents. The provider failed to demonstrate adequate oversight and scrutiny of the service considering the findings of reviews and the most recent inspection completed by the Office of the Chief Inspector.

This issue of inadequate governance and management was also identified at the previous inspection and the compliance plan stated that this would be addressed by

January 2019.

Judgment: Not compliant

Quality and safety

Inspectors found, that while there were efforts made by front line staff to promote person centred care, the governance and management arrangements in place in the centre did not ensure the quality and safety of the service provided. Areas for improvement included safeguarding, upholding of residents' rights, personal plans, medication management, risk management, premises, positive behaviour support and management of restrictive practices. A number of these issues had been identified at the previous inspection in December 2018, and inspectors found that the provider had not adequately addressed key areas of concern. Examples of these areas are discussed later in the report.

The inspectors found that there had been some improvement in the management of safeguarding concerns. Potential safeguarding incidents were reviewed and investigated, and safeguarding plans were in place for some of the risks identified. However, inspectors found that not all safeguarding concerns were investigated or responded to appropriately. A safeguarding concern raised by staff members had been screened prior to the inspection in December 2018, where inspectors found that the measures in the safeguarding plan had not been implemented, and that the safeguarding risk had not been reviewed appropriately. Despite further concerns raised by staff in relation to this matter, the provider had not addressed it in line with their own safeguarding policy, and there were inadequate safeguarding measures in place at the time of inspection.

The previous inspection found that there were a number of compatibility issues among the resident group. After the inspection, one resident had been discharged to another service in line with their assessed needs. While the number of incidents appeared to have reduced, the March 2019 staff team minutes note that this may be due to under reporting of incidents. The inspectors reviewed a sample of daily files and found that there remained a number of incidents involving behaviours of distress pertaining to one resident which continued to impact on other residents living in the centre.

Inspectors found that improvements were required to support residents to exercise their rights, and to participate in, and consent to decisions about their care and support. The provider had supported a resident to avail of an independent advocate, which was a positive step in supporting the resident to exercise choice and control in their life. However, further improvement was required to ensure that where residents were restricted from exercising their rights, that this was identified and addressed. Inspectors found that residents were facilitated to make choices on a daily basis, and that staff supported residents to make decisions about

their day to day care. However, it was found that residents were not always central to decisions about their care and support on a wider scale, and in some cases, decisions were made in the absence of consultation with residents, for example, in relation to residents' finances.

The inspectors reviewed a sample of residents' files and found that there was an up-to-date comprehensive assessment of need in place, from which personal plans were developed. It was identified at the previous inspection that some personal plans did not adequately guide the staff team to support residents. The provider had completed an audit of personal plans since that inspection, and identified similar issues, and there was an action plan developed to address this. While there was evidence of some review of personal plans since the last inspection, inspectors found that a large proportion of the actions remained outstanding.

The inspectors reviewed a sample of residents' positive behaviour support plans, and found that where residents required support to manage their behaviour, a support plan was developed by an appropriate allied health professional. Inspectors found that there were multiple versions of positive behaviour support plans in place for one resident, and that some behaviours that required support (as evidenced by daily logs and incident reports) were not included in plans.

There were some restrictive practices in use in the centre, and each had been reviewed by a positive approaches monitoring group. Inspectors found that in some cases there was insufficient assessment of risk to justify a restrictive practice, and that there was inadequate evidence that a lesser restrictive method was used in the first instance.

The centre maintained a risk register and there were systems in place for the assessment and management of risk. However, as per the previous inspection it remained that risk assessments were not reflective of the risks within the centre and the controls in place to manage the risk. For example, as highlighted above, there was no risk assessment in place for a residents behaviour that was rationale for the use of a restrictive practice. Furthermore, some risks were rated disproportionately high, with restrictive control measures, with other assessments in place that did not support a high risk rating.

It remained that residents were not protected by the provider's medication management policy. At the last inspection, it was identified that the protocols in place for administering PRN (medicine administered as required) medication required significant improvement. On the day of the inspection, it was found that PRN medication protocols had not been developed, despite further PRN medicine being prescribed in the interim for one resident. It remained that one resident was prescribed multiple pain relief medication, without clear guidance on the indications for administering each. In addition, there were a number of significant medication errors identified in the centre, as well as others recorded in staff communication but not recorded as an error. It was found that the response to medication errors was not carried out in line with the provider's procedures, and that generic actions were recommended following each review. In some cases, medication had been recorded

as missing, and this had not been followed up on.

The inspectors completed a walk through of the house and adjoining apartment. The house is a two storey building and at the time of inspection was home to five residents and consisted of a storage room, toilet, utility room, kitchen, dining room/living room, two bathrooms, two offices and six individual bedrooms. The adjoining apartment was home to one resident and consisted of a kitchen, living/dining room, utility room, staff room, bathroom and bedroom. The availability of storage in the centre required review as inspectors observed fire evacuation equipment being stored inappropriately in the bathroom. There were some areas of the centre which required maintenance including painting, flooring. This had been identified by the provider and was in the process of being addressed.

Regulation 17: Premises

Areas of the premises required improvement including:

- The availability of storage in the centre required review as inspectors observed fire evacuation equipment being stored inappropriately in the bathroom.
- There were some areas of the centre which required maintenance including painting and flooring.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider failed to complete this previously identified action to address this area of non compliance as per their action plan submitted to the Office of the Chief Inspector 22 January 2019. The centre maintained a risk register and there were systems in place for the assessment and management of risk. However, risk assessments were not reflective of the risks within the centre and the controls in place to manage the risk.

This was also identified at the previous inspection and the compliance plan stated that this would be addressed by January 2019.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider failed to complete this previously identified action to address this area of non compliance as per their action plan submitted to the Office of the Chief Inspector 22 January 2019. PRN (as required) medication protocols did not appropriately guide staff in the administration of these medications.

This was also identified at the previous inspection and the compliance plan stated that this would be addressed by January 2019.

In addition, there were a number of significant medication errors identified in the centre, as well as others recorded in staff communication but not recorded as an error. It was found that the response to medication errors was not carried out in line with the providers procedures

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider failed to complete this previously identified action to address this area of non compliance as per their action plan submitted to the Office of the Chief Inspector 22 January 2019. There was an up-to-date comprehensive assessment of need in place and personal plans were developed from this assessment. However, it remained that a number of personal plans did not adequately guide the staff team to support residents.

This was also identified at the previous inspection and the compliance plan stated that this would be addressed by February 2019.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans developed by an appropriate allied health professional were in place where required. However, there were multiple versions of positive behaviour support plans in place for one resident, and some behaviours that required support were not included in plans.

There were some restrictive practices in use in the centre, inspectors found there was an insufficient assessment of risk to justify a restrictive practice, and that there was inadequate evidence that a lesser restrictive method was used in the first

instance.

Judgment: Not compliant

Regulation 8: Protection

The provider failed to complete all aspects of this previously identified action to address this area of non compliance as per their action plan submitted to the Office of the Chief Inspector 22 January 2019; the inspectors found that there had been some improvement in the management of safeguarding concerns. However, not all suspicions of abuse were investigated or responded to appropriately.

This was also identified at the previous inspection and the compliance plan stated that this would be addressed by January 2019.

Judgment: Not compliant

Regulation 9: Residents' rights

Some practices in place in the centre did not promote residents' automony, independence and choice.

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
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Grangemore Rise OSV-0002341

Inspection ID: MON-0026261

Date of inspection: 25/04/2019

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Currently there is a whole time equivalent of 12.7 staff. • A nursing assessment of all residents needs was undertaken and showed that current residents do not have specific nursing needs. Therefore the skill mix in the house is under review. An application to vary the statement of Purpose will also be submitted to the authority in regard to changes in skill mix. • Currently there are 2 X WTE vacancies for Social Care Workers. Recruitment is in process to replace all current vacancies within the centre. • One of these vacancies is being covered by a regular relief SMH staff member. • The other vacancy is covered by regular relief/ agency/ Regular staff doing additional hours, as much as possible. • A new Person in Charge will commence in the centre on 12th June 2019. This person has more than 3 years experience as a Clinical Nurse Manager 2 and has managed significant change and quality improvement in other area's of SMH. Documents will be submitted within timeframes. • Persons Participating in Management will also change as of 22nd May 2019, all documents will be submitted within time frames. • Any absence of the PIC will be notified to the authority if greater than 28days. • The person in Charge will continue to keep a planned and worked roster.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and	

staff development:
• A full audit of staff training was completed on 8th Jan 2019 and training plan developed for the remaining year. A further audit of all staff training needs will be conducted by the new Person In Charge and any outstanding training will be scheduled as a matter of urgency.
• Currently all staff are up to date in all mandatory training.
• New staff to the centre require training in Therapeutic Interventions Promoting Safety / Safe Administration of Medications/ Positive Behavioral Supports. This will be scheduled and facilitated as soon as possible from their start date.
• The person in Charge will conduct support meetings with all staff as per SMH policy. Any training needs identified at these meetings will be facilitated.
• Training facilitated by the Allied Healthcare Team will be facilitated as per the identified needs of current residents.
• The new PIC will liaise with the Organizational Fire Prevention Officer to identify a date for team training.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Following the last Inspection the Statement of Purpose has been revised and returned to the Authority on 2nd May 2019.
• The Staff WTE was reviewed and updated to ensure it was correct.
• The protocol around Emergency admissions was also reviewed and updated to ensure it is in line with SMH policy.

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

Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:
• Any absence of the Person in Charge greater than 28 days, whether planned in advance or unplanned, will be notified to the Authority within specified timeframes.
• An identified experienced staff member will cover the absence of the Person in Charge as per the Statement of Purpose.

Regulation 34: Complaints procedure	Not Compliant

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

• The current Person in Charge has reviewed all current complaints to ensure they have been investigated / closed if applicable.
• All future complaints will be managed in line with current SMH policy.
• A log of all complaints is kept / detailing the stage they are at / whether the complainant is satisfied or not.
• Documentation is kept in regard to measures put in place to improve quality and Safety following the investigation of a complaint.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• There are clear management structures in place in the centre. A new PIC will commence in the centre on 12th June 2019.
• The current identified PPIM's have changed as of 22nd May 2019.
• All documentation pertaining to the changes of PIC and PPIM will be notified to the Authority within identified timeframes.
• Organizational governance structures are in place, Annual Report specific to the centre/ 2 X 6 Monthly unannounced Quality and Safety visits / Health and Safety Audits/ Infection Control Audits/ Yearly Fire Risk Assessments.
• Local governance structures are also in place, monthly data sheets/ Medication Management audits/ local health and safety audits/ Monthly financial audits of all residents finances/ personal planning audits/ local fire safety checks/ audits on all restrictive practices.
• Local tracking structures are in place to track: drug errors/ restrictive practices/ complaints/ incidents and accidents/ Fire drills and walk around.
• Safeguarding of residents is managed in line with SMH policy, which is underpinned by National policy. The current SMH policy is currently under review and will be available on 30th May 2019.
• The PIC will ensure all staff are supported formally as per SMH policy
• The PIC is supported/ supervised by the Service Manager in line with SMH policy. The PIC is also supported via peer support in the form of cluster meetings.
• Risk is managed in line with SMH policy: all risks are identified on the local risk register which is escalated via the Service Area Risk Register to the Organizational Risk Register.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• There is a storage shed in the back garden. All storage areas in the centre have been cleared of inappropriate items in order to create space.
• All fire Safety equipment is stored appropriately. The new PIC will liaise with the Organizational Fire Prevention Officer to identify a date for team training.
• The small sitting room has been re decorated to ensure it meets residents needs.
• All communal area's in the centre will also be painted.
• Flooring throughout the centre has been inspected and new flooring put in where required.
• The new PIC will work with all staff and residents to ensure the house is homely/ welcoming and personal to the individuals living there.
• All actions arising from Organizational audits and pertaining to premises will be auctioned in a timely manner.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The current PIC has completed the Risk assessment training on 25th March 2019.
• The new PIC completed Risk Assessment training on 6th March 2019.
• The current and new PIC will complete a full review of all risk assessments to ensure they are comprehensive/ fit for purpose and up to date.
• Risk is managed in line with SMH policy: all risks are identified on the local risk register which is escalated via the Service Area Risk Register to the Organizational Risk Register. The risk register is reviewed and updated quarterly by the PIC and more often as required.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The management of medications in the centre is managed in line with SMH policy.

Organizational policy is underpinned by National Policy.
• PIC met with the Organizational Health and Medical trainer on 18th March 2019 to develop action plans in order to ensure systems are consistent and fit for purpose.
• All staff are up to date in the safe administration of medication training. The new PIC will ensure that all new staff receive training as soon as possible from their start date.
• All nurses in the centre have completed refresher training in the safe administration of medications organizationally and via the HSE.
• Local trackers/ audits are in place in regard to the management of medications.
• The PIC ensures that all learning gained form Audits / incidents/ errors is shared with the full staff team.
• All PRN medications are managed in line with Organizational policy. All PRN medications have information/ plans to adequately guide practice.

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:
• All residents have an assessment of need in place and up to date. Personal plans individual to each resident are also in date and in place. All personal plans are reviewed / evaluated to ensure they adequately guide practice.
• The PIC and two Social Care Workers completed a full audit on all personal plans on 24th April 2019. Actions arising from this review have been identified an put in place and will be evaluated to ensure consistency and effectiveness.
• The organizational Person Centered Planning coordinator completed a full audit of all PCP systems/ Plans on 18th April 2019. All actions/ recommendations identified in the report will be auctioned by the staff team in a timely manner.
• All residents have a yearly wellbeing review to ensure their personal planning systems are fit for purpose.
• All current residents have had a nursing needs assessment in March 2019, all Assessment of needs and personal plans have been reviewed/ up dated in line with the recommendations from these assessments.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• All staff are trained in Positive Behavioural Supports. All staff work in line with SMH

policy.
• All new staff to the centre will be facilitated to attend training as soon as possible from their start date.
• The PIC will review all restrictive practices to ensure they are fully fit for purpose. Risk assessments / approval documentation / plans to review-evaluate-remove are also in place.
• PIC and PPIM will ensure that there is Local guidance for staff in regard to transparent documentation to ensure consistency / quality and safety for all.
• Following the above the new PIC in consultation with the Senior Psychologist will complete a full review of all restrictive practices/ current behaviours that challenge, to ensure all positive behavioural supports are in place. If required the positive behavioural support plans will be reviewed and updated accordingly following this.
• Local team supports / training is in place from relevant members of the Allied Healthcare Team.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Current SMH policy on the protection of vulnerable adults is under review and will be available from 30th May 2019. The Organisational policy is being reviewed in line with National Policy.
• All staff have up to date training on safeguarding vulnerable adults.
• All staff have completed Children's first training via the HSE.
• All concerns relating to the safeguarding of residents are Screened / notified in line with Organisational/ National policy and Regulatory requirement.
• Comprehensive Safe guarding plans / risk assess are in place for each resident where required.
• Staff are trained in Therapeutic Interventions Promoting Safety (TIPS). The PIC will ensure that all new staff to the centre receive TIPS training as soon as possible from their start date.
• The new PIC / Accounts Department will conduct a comprehensive Financial audit for all residents. All concerns regarding the management of Service Users finances will be assessed/ actioned in line with Organisational policy.
• Referrals have been submitted by the PIC to the National Advocacy Service for residents who require their support.
• Members of the Allied Healthcare Team are available as required.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Each resident is supported to exercise control in their lives by choice and participation.
• Each resident has access to external advocacy services as required.
• Each resident has a key worker who supports them in conjunction with their family, to live the life of their choosing.
• Each resident has a wellbeing meeting each year facilitated by their keyworker to review all areas of their life. All residents are facilitated to attend meetings in regard to their care as and when they choose.
• The new PIC will liaise with the Organizations training dept and outside agencies RE: team training in rights / self advocacy for residents and National Policy in regard to Assisted Decision making.
• Residents are facilitated to have peer to peer meetings locally. Each person personal communication needs are taken into account and supported.
• The Organization is committed to the formation of a Rights committee which will include Service Users. This committee will be responsible for reviewing all concerns / complaints in regard to 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	27/09/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/10/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	30/05/2019

	kept in a good state of repair externally and internally.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/06/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/06/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	28/06/2019
Regulation 29(4)(b)	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	Not Compliant	Orange	27/05/2019

	of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
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	27/05/2019
Regulation 32(3)	Where the person in charge is absent from the designated centre as a result of an emergency or unanticipated event, the registered provider shall, as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more, give notice in writing to the chief inspector of the absence, including the information referred to in paragraph (2).	Not Compliant	Orange	27/05/2019
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	27/05/2019
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably	Not Compliant	Orange	27/09/2019

	practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
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	28/06/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	28/06/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	27/05/2019
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her	Not Compliant	Orange	27/09/2019

	disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			