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Dunfirth Farm, OSV-0005451, 16 May 2019

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Office of the Chief Inspector

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

Name of designated centre:	Dunfirth Farm
Name of provider:	Health Service Executive
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	16 May 2019
Centre ID:	OSV-0005451
Fieldwork ID:	MON-0027031

About the designated centre

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

At the time of inspection, the centre provided residential care and support for 32 adults on the autistic spectrum. The centre comprised of eight individual houses and six single unit apartments supporting both male and female adult residents. The majority of the residents had been living in the centre for more than 20 years. The centre was located in a rural setting on a large campus. The centre had a number of vehicles in place to transport residents to social and recreational activities in the community. The campus included a stand alone building, named the training unit, where a number of residents engaged in a activities such as art and cooking classes. There was also a smaller building, where pottery classes were undertaken. The campus had a large garden and a poly tunnel where some residents engaged in horticultural activities. This centre was a specialised residential service on a campus based setting supporting adults on the autistic spectrum. The centre was previously operated by the Irish Society for Autism (ISA). Due to high levels of non compliance and risk to the residents HIQA issued a notice of decision to cancel and refuse the registration of Dunfirth Farm in May 2016. In accordance with Section 64 of the Health Act the Chief Inspector made alternative arrangements with the Health Service Executive (HSE) to take over the running of the centre. The HSE have a memorandum of understanding in operation with another service provider, Inspire Wellbeing to support the management of the centre with its day-to-day operations and to commence putting systems in place to improve outcomes for all residents living there. Under the current Health Service Executive (HSE) governance and management arrangements , this was the fourth unannounced monitoring inspection (the last one being March 2018) and was to assess the centres level of compliance against the Regulations.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:

32

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
16 May 2019	07:50hrs to 18:00hrs	Andrew Mooney	Lead
16 May 2019	07:50hrs to 18:00hrs	Marie Byrne	Support

What residents told us and what inspectors observed

In response to the needs of residents, inspectors did not engage verbally with residents for any extended time. The inspectors judgments in relation to the views of the people who use the service, relied upon observation of residents, documentation, brief interactions with residents and discussions with staff. Inspectors met with 10 of the residents who used the service. Some residents spoke with the inspectors and noted that they were happy in the centre. Residents appeared comfortable in the company of staff.

However, inspectors noted that many residents remained within the campus for much of the day, with limited opportunity to access the community individually. Furthermore, inspectors observed parts of the premises not kept in a good state of repair and requiring cleaning. This negatively impacted the homeliness of the centre. Inspectors also observed a resident who required assistance as a result of their assessed needs, however there was a delay in this resident receiving appropriate support and this was raised with the provider.

Capacity and capability

This inspection found that the current governance and management arrangements were inadequate and led to some residents being exposed to unacceptable risk. These arrangements did not assure the delivery of high-quality, person-centred care and support. Significant improvements were required in staff recruitment practices to ensure all staff had an appropriate Garda vetting report.

The last inspection in March 2018, identified concerns relating to the role of the person in charge within this centre. In response to these concerns the provider had increased the number of team leaders within the centre to assist the person in charge. Inspectors found that the centre was managed by a suitably qualified, skilled and experienced person. The person in charge was found to have a good knowledge of the care and support requirements for residents living in the centre and was in a full time post. However, the person in charge was responsible for another designated centre and given the geographical size of this campus, the number of residents and the number of staff, inspectors found the person in charge did not have the capacity to be effectively engaged in the governance, operational management and administration of the centre.

There was a management structure in place that identified lines of accountability and responsibility. However, the governance arrangements in place were not robust and meant that the lines of accountability and responsibility were not clear. The

providers quality assurance system did not effectively identify and resolve service deficits, for example there was a governance system in place that entailed a member of the management team engaging in a daily walk around of the centre to ascertain if there were any issues of concern. This system failed to identify and reduce risks that were visibly identifiable to inspectors on the day of inspection. Additionally, the governance and management arrangements in place did not have appropriate oversight of the staff roster, which led to inappropriate staffing arrangements on occasion. This was discussed with the provider during the inspection. Furthermore, the annual review of quality and safety of care and support of the centre was not available to inspectors during the inspection. It was therefore not clear that suitable arrangements had been made to ensure this review had been completed and that learning was identified.

During the inspection it was clear from a review of staff rosters that there was insufficient staff to meet the assessed need of residents and this was confirmed by the the person in charge. The provider had made a concerted effort to address the lack of staff, however the centre was still unable to cover all the planned shifts on the roster. The provider utilised a large number of agency staff to try and address staffing deficits but had not implemented appropriate systems to ensure that all schedule 2 information was received for these staff. This resulted in the the provider being unclear if all agency staff working within the centre had appropriate Garda clearance certificates in place. Inspectors issued an immediate action to the provider and requested assurances that the provider received confirmation that all staff had an appropriate Garda vetting report and proof of their identity. These assurances were provided post inspection. The centre had a planned and actual roster in place. However, these rosters required improvement as they were not always accurate. For instance a staff member was documented has having worked within two separate parts of the designated centre simultaneously, it was therefore unclear if safe staffing levels were in place. Additionally, it was unclear which members of the the management team were working and if they were due to work on site or off site.

Throughout the inspection inspectors engaged with staff and observed staff practice. Staff were respectful towards residents and generally appeared to understand their needs. However, on one occasion inspectors observed staff not following agreed protocols in the management of a residents assessed healthcare needs. Despite a staff member confirming to the person in charge that the healthcare related protocol had been followed, it later transpired that this protocol had not been followed. The mismanagement of this adverse incident could have seriously impacted the resident. This was raised with the provider on the day of inspection and the provider committed to investigating the incident.

Staff were provided with suitable training such as fire safety, manual handling, positive behaviour support and autism training. There were some gaps in this training but the provider was aware of these gaps and had made arrangements to address them and ensure all mandatory training was provided. The provider had recently begun to implement a new staff supervision system. This system was in its infancy and required improvement to ensure all staff received supervision as per the

providers policy.

Regulation 14: Persons in charge

The person in charge managed more than one designated centre and could not ensure the effective governance, operational management and administration of the designated centre concerned.

Judgment: Not compliant

Regulation 15: Staffing

There was inadequate evidence of schedule 2 documentation being recorded for all staff, for example agency staff records were not available during the inspection. The staffing levels within the centre were not adequate to meet the assessed needs of residents. Residents were not appropriately supervised to ensure their assessed needs were being met. The planned and actual roster required improvement as it was not accurate, for example it was unclear if management were working on site or off site and not all staff members full names were recorded.

Judgment: Not compliant

Regulation 16: Training and staff development

The education and training provided reflected the statement of purpose.

Staff supervision systems were in their infancy and did not ensure all staff were adequately supervised.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider could not demonstrate that they were self identifying and resolving service deficits. The annual review of quality and safety of care and support of the centre was not available to inspectors during the inspection.

Judgment: Not compliant

Quality and safety

Overall the quality and safety of the service delivered to residents was adversely impacted by the poor adherence to organisational policies. The maintenance of the premises, safeguarding measures, access to appropriate allied healthcare professionals, fire containment measures and the opportunity for residents to engage in meaningful activities required significant improvement. The high levels of non compliance resulted in the lived experience of residents being negatively impacted.

The centre was located in a rural setting on a large campus. The campus included a stand alone building, named the training unit, where a number of residents engaged in activities such as art and cooking classes. There was also a smaller building, where pottery classes were undertaken. The campus had a large garden and a poly tunnel where some residents engaged in horticultural activities. The design and layout of the premises did not lead to all residents living in a safe, comfortable and homely environment. During a walk around of the premises inspectors observed parts of the the centre being unclean and not kept in a good state of repair. For example inspectors observed what appeared to be faeces in some areas, broken glass in external communal areas and broken tiles in a bathrooms. Furthermore, there was an area within the designated centre that required urgent attention due to the risk it posed to staff and residents. This was discussed with the provider and they took interim measures to ensure the area was safely contained.

Residents' had an assessment of need and a personal plan in place. The inspectors acknowledge that the provider was in the process of implementing a new system for individualised assessment and personal planning in the centre. Each residents had a personal plans in place and they had access to a keyworker to support them. However, on reviewing a sample of residents' personal plans, it was identified that a number of residents' assessment of need required review to ensure they were fully completed, reflective of residents' needs and guiding staff to support them fully. Additional information in relation to residents' care and support needs was contained within residents' personal plans, however on occasion these did not correspond with their assessment of need. Furthermore inspectors found that one residents' needs were not being fully supported in the centre. The arrangements in place to support this resident involved their living and sleeping accommodation being separated across the campus and they did not have access to their belongings without staffs' support.

Residents healthcare needs were assessed and they had health action plans in place to assist them to enjoy best possible health. Residents had access to a general practitioner and had an annual medical review completed. In addition, they had access to regular reviews with their psychiatrist if required. However, not all residents had access to allied health professionals in line with their assessed need,

including occupational therapists, speech and language therapists and behaviour therapists on an ongoing basis. The provider had sourced allied health professionals to carry out assessments for a number of residents. However, these assessments had not been regularly reviewed or fully implemented. For example, the inspectors reviewed records which demonstrated that one residents' healthcare plan was not being fully implemented on a daily basis. This healthcare plan related to their nutrition and hydration needs.

There were a number of restrictive practices in the centre and there was evidence that these were assessed and reviewed regularly. There was evidence of a reduction in the use of some restrictive measures for a number of residents in the centre since the last inspection. However, there were a number of restrictions in place which had not been identified and so were not notified in line with the requirements of the regulations. Staff had access to training to support residents in line with their care and support needs. Inspectors spoke to a number of staff who were knowledgeable in relation to each residents' specific support needs. However, staff did not have access to up to date assessments or support plans to guide them to support all residents, as not all residents had access to appropriate allied health professionals. The inspectors noted that the provider was aware of this and had recently secured the support of a behaviour specialist for a number of priority residents.

There were appropriate policies and procedures in place and staff had access to training to support them to carry out their roles and responsibilities in relation to safeguarding residents. Staff who spoke with the inspectors were knowledgeable in relation to what to do if there was an allegation or suspicion of abuse in the centre. Residents had intimate care plans in place which were guiding staff to support residents in line with their wishes and preferences. However, in one instance inspectors found that agreed safeguarding measures were not put in place in line with residents' safeguarding plan. This was discussed with the provider during the inspection and the inspectors requested assurances that actions were taken to ensure safeguarding plans were being fully implemented, these assurances were given post inspection.

The inspectors found that residents had limited access to opportunities to participate in activities and link with their local community. The inspectors acknowledged that some efforts were being made to support residents to engage in meaningful activities in line with their wishes and preferences. Residents' social care assessments were in place and identified residents' preferred activities. However, due to staffing numbers and lack of access to transport at times, residents' opportunities to engage in these activities or reach their social goals were limited. The inspectors reviewed a number of activity records for a one month period and found that the majority of activities were group based, with only two occasions during the month where residents were supported in a 1:1 basis to engage in meaningful community based activities. Of the activity records reviewed, two residents did not have any community based activities recorded during the month.

The centre had systems in place for the management of fire. However, improvements were required. Inspectors found that the equipment such as

extinguishers, emergency lighting and fire alarm were appropriately serviced. The centre had personal emergency evacuation plans in place for each resident which outlined how to support each resident in the event of an evacuation and regular fire drills were occurring in line with the regulations. The centre had fire doors throughout but inspectors observed some fire doors were not closing properly. Additionally, there was internal glass panel within a fire door which in the event of a fire would form part of a fire containment strategy and the provider was unclear if this contained appropriate fire containment properties. An immediate action was issued to the provider and assurances were given on the day of inspection that all fire doors closed appropriately.

The centre maintained a risk register which outlined the risks in place in the centre such as slips, trips and falls, staff shortages and behaviour. In addition, individualised risk assessments were completed for residents including mobility and eating and swallowing. However, the inspectors found that not all risks were being appropriately managed. For instance a set of stairs was blocked with a bench, this presented as a serious trip hazard. The provider had identified this risk but had failed to ensure measures were taken to remove the risk. Additionally, it was unclear why this area was being blocked and the provider was unsure if this related to fire safety concerns or a lack of compliance with building regulations. Furthermore, there was a serious risk associated with a residents assessed needs, that was not being appropriately managed. This was raised as an immediate action with the provider and assurances were given that immediate measures would be taken to address these concerns.

Residents were protected by appropriate policies and procedures relating to the ordering, receipt, storage and disposal of medicines. Audits including stock control were completed regularly and incidents were documented. However, on reviewing incident reports in the centre, the inspectors found that control measures and actions listed following review an incident, had not been implemented. The provider gave assurances to the inspectors during the inspection, that the actions listed would be implemented. Staff had access to training in the safe administration of medication and practical administration prior to administering residents' medicines. In addition, protocols were in place to guide staff practice in relation to some as required medications for a number of residents. The provider outlined to the inspectors that they had plans in place to explore if residents wished to take part in any aspect of self-administering their medicines. Assessments had been previously completed for a number of residents, however; they had not been reviewed or updated for a number of years.

Regulation 13: General welfare and development

Residents had limited opportunities to participate in activities in line with their wishes and preferences. For instance inspectors reviewed a number of activity records for a month period and found that the majority of activities were group based. There were only two occasions during the month where residents were

supported in a 1:1 basis to engage in meaningful community based activities. Of the activity records reviewed, two residents did not have any community based activities recorded during the month.

Judgment: Not compliant

Regulation 17: Premises

Areas within the centre were unclean and not kept in a good state of repair. Inspectors observed what appeared to be faeces in some areas, broken glass in external communal areas and broken tiles in a bathrooms. Not all schedule 6 arrangements were in place i.e. Suitable arrangements for the safe disposal of general and clinical waste where required.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was a risk management policy and appropriate practices in place, however there were a number of hazards which were not appropriately managed which could cause injury. For instance a set of stairs was blocked with a bench, this presented as a serious trip hazard.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire equipment was provided and serviced as required. Staff showed enough knowledge and understanding of what to do in the event of a fire. However, some fire doors did not close as intended or were wedged open.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Overall, residents were protected by policies, procedures and practices in relation to medicines management. However, control measures and actions following an incident needed to be implemented. The provider outlined plans to explore if

residents wished to take part in any aspect of self-administering their medicines.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider was in the process of implementing a new system for individualised assessment and personal planning in the centre. Residents' had personal plans in place and access to a keyworker to support them. However, on the day of the inspection some residents' personal plans and assessments of need required review to ensure they were fully completed, reflective of residents' needs and guiding staff to support them fully.

Judgment: Not compliant

Regulation 6: Health care

Residents had a healthcare assessment in place and health action plans developed as required. They had access to an annual medical review with their general practitioner and to a psychiatrist for support as required.

However, not all residents had access to allied health professionals in line with their care and support needs. On review of residents' healthcare assessments the inspectors found that one residents' healthcare plan was not fully implemented.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There were a number of restrictive practices in place due to the assessed needs of the residents. These practices were applied in accordance with evidence based practices and national policy. Staff had received training to support residents in line with their assessed needs. However, there were a number of restrictions that had not been recognised as such or reported in line with the requirements of the regulations. In addition a number of residents did not have access to the support of relevant allied health professionals in line with their care and support needs.

Judgment: Not compliant

Regulation 8: Protection

Staff had completed training in relation to safeguarding residents and staff who spoke with the inspector were knowledgeable in relation to their responsibilities in relation to what to do if there was an allegation or suspicion of abuse in the centre. However, not all safeguarding plans in the centre were being fully implemented.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Dunfirth Farm OSV-0005451

Inspection ID: MON-0027031

Date of inspection: 16/05/2019

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 14: Persons in charge	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 14: Persons in charge:</p> <p>The provider will submit two applications, separating the current Designated Centre into two separate Designated Centres. Within each proposed Designated Centre the provider will employ a full time Person In Charge with the skills and experience required to manage the needs and complexity of each Designated Centre. Within each proposed Designated Centre the PIC will be supported by a team of Team Leaders sufficient to support the role of the PIC and assist in an effective governance, operational management and administration of the Designated Centres. Subject to an agreed signed lease, applications for two separate Designated Centres will be submitted by 30.08.2019.</p>	
Regulation 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>All staff files, including both the Organisation’s and agency staff have been reviewed and are now compliant with Schedule 2 documentation 26.06.2019. All staff coming through the Organisation’s recruitment processes are required to complete all Schedule 2 requirements prior to commencing in post. Agencies are required to provide Schedule 2 compliance information prior to the staff coming on site. When staff present for their first shift they are required to present with identification matching their Schedule 2 information before being allowed to pass the main office. All rosters now use the full name of the person as per the Garda Disclosure documentation rather than shortened or assumed names. 26.06.2019</p>	

As a result of the assessed needs of residents, staffing levels have increased over the past number of months, and the Organisation continues to recruit new staff which will reduce the historical issue of using agency staff. Interviews for Coworkers took place 14.06.2019, which resulted in 4 full-time coworkers being selected and are currently going through the Organisations recruitment checks. A recruitment fair took place in the local area on 13.06.2019, with further advertising for staff and this process will continue until all vacant posts are filled.

A Deputy Manager commenced in post 10.06.2019 on a part-time basis due to become full-time in July 2019. An additional part-time Team Leader commenced 24.06.2019. Consultation is ongoing with staff regarding changes to the overnight provision of staff for the centre with proposals for additional waking night staff taking into account of the changing needs of residents. Final staff profiles will issue as part of the proposal to apply for two designated centres as per Regulation 14 by the 30.08.2019

The Person in Charge has ensured that both the planned rota and the actual rota include full names of staff, identifying the hours that management are on and off site. The Person in charge will sign off on the actual rota each working week. While there are additional staff being employed the core staff teams for each house are being maintained to ensure consistency across houses.

Regulation 16: Training and staff development	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

The management team had received training in relation to the Organisation’s supervision and performance management processes in March 2019. Supervisions had commenced on site at the time of the inspection 16 May 2019 and the PIC has ensured that supervision schedules are in place covering all support staff for the six months to 31.12.2019. The schedules ensure that each staff will receive a minimum of four supervisions annually 01.07.2019.

Training plans are in place with a full schedule of training and refresher training available to staff. Areas of non-compliance within the training matrix have been targeted and training courses have been scheduled to eliminate non-compliances in the coming months 31.10.2019.

Arrangements are in place to meet with staff to discuss the Inspection report and action plans 02.07.2019

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Bi-annual inspection carried out 18.12.2018 and annual inspection carried out 14.02.2019. The current Provider will continue to complete the Regulation 23 visits as required until the application for new proposed Provider has been accepted. In addition to the Regulation 23 visits, the new proposed Provider continues to carry out monthly monitoring audits on the service, and these are also available for inspection.</p>	
Regulation 13: General welfare and development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 13: General welfare and development:</p> <p>A process of voice and choice monthly meetings identifies the residents preferred activities and choices. The voice and choice process is undertaken either individually or group based dependent on capacity and preference. The choices identified are then transferred to the weekly activity planners, which triangulate with the residents' daily notes once completed. A process is now in place to display the activity planner and the actual activity as a collective document. All residents' daily documentation will then be reviewed during monthly monitoring visits and any non-attendance of residents at activities will be noted and reasons for same identified 05.07.2019.</p>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>The PIC has completed a review of the cleaning schedules across the services, revised cleaning rotas and infection control protocols are in place for the Designated Centre. These cleaning rotas and infection control protocols are also standing item on the agenda for monthly house meetings for the next three months. 05.09.2019.</p> <p>Clinical waste bins have been placed in houses where clinical waste needs apply 26.06.2019</p> <p>A review of the general waste arrangements has taken place and orders are in place for</p>	

some alternate waste disposal bins 05.07.2019

A detailed list of all maintenance issues has been collated and contractors have been submitting quotations for various works including replacement of some bathrooms, kitchens, windows etc. The quotations are being submitted to the provider and works prioritized in relation to risk and health and safety concerns. Contractors will be engaged for the priority works in line with arrangements to protect residents experience while works take place. A full environmental compliance strategy will be shared with the Inspectors as required.

Regulation 26: Risk management procedures

Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The PIC ensured that all hazards identified on the day of inspection were immediately actioned.

The risk register for each house in the Designated Centre identifies potential hazards and the register is a standing item on the monthly house meeting agendas 05.10.2019.

There are ongoing systems and processes of risk identification and minimization which are identified through the incident management processes and the review of the risk registers. The risk registers of each house are to be combined to be encompasses in a service wide risk register 05.07.2019.

There is also a "Dunfirth Farm" Risk Management Tool that is reviewed by the Organisation's Quality and Risk Committee, and is also shared with Organisations Trustee.

Regulation 28: Fire precautions

Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Any fire doors that required adjustment on the day of inspection were immediately actioned. The Fire equipment contractor will complete the full quarterly servicing of all fire equipment relating to alarms, fire doors, emergency lights and this took place 26.06.2019

A glass panel identified on the day as not displaying a fire rating signature has been

replaced 27.06.2019

The fire extinguishers are to have their annual servicing and scheduled replacements by 01.08.2019

Communication has gone to all staff in relation to the propping open of fire doors that this practice is to cease immediately. Management and Maintenance teams oversee the Designated Centre on a daily basis and ensure that no fire doors are being propped open 05.07.2019

Weekly Fire Safety checks will be completed across all properties

Regulation 29: Medicines and pharmaceutical services

Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

The action identified on the day of the inspection that had not been completed was completed the following morning 17.05.2019.

The incident management processes identify actions and the PIC follows through each incident with any instruction in relation to the incident. The incidents are discussed as a standard agenda item in each house meeting on a monthly basis.

The MDT Nurse commenced the process of assessing capacity and interest in participation in self-administration of their medicines 05.07.2019

Regulation 5: Individual assessment and personal plan

Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

The Person in Charge will ensure that all residents' needs and supports required to meet these needs are identified and outlined in their corresponding support plans. The PIC will ensure that each resident has the opportunity to participate in an annual review of their support and this will be reflected in their support plan. The annual review process will involve the identified multi-disciplinary supports of the resident. The support plans will be discussed at monthly house meetings and signed off by staff to advise they understand the contents and the guidance to follow the supports outlined 31.10.2019

Regulation 6: Health care	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 6: Health care: The PIC has ensured that all residents receive a full annual health check through the GP service and receive relevant referrals for any identified health concerns. Where there is a requirement to support an ongoing health need for the residents the PIC will ensure that the health action plan reflects the health need and actions as described by the relevant medical professional and that staff are aware and sign off on their responsibilities for completion of actions.</p> <p>The PIC will ensure this is managed through the daily management oversight of the designated centre and the clinical governance processes. There is a scheduled review of health needs every six months with the GP services. In addition to the full annual health check each resident receives a psychiatric review on an annual basis.</p> <p>The provider has identified Multi-disciplinary support services with a view to providing the relevant MDT supports for each referred resident, including the assessed needs and planned supports in the support plan for each resident 31.10.2019</p>	
Regulation 7: Positive behavioural support	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The rollout of restrictive practices training continues and there were further training sessions on this 28.05.2019. There is continuous work in respect of Positive Behaviour Support Plans for specific residents and the relevant staff teams are being trained as part of the implementation of these. Additional restrictive practices are being identified and documented within the restrictive practices register and there is a review of restrictive practices on the agenda for house meetings on a monthly basis.</p> <p>The provider has identified Multi-Disciplinary supports with a view to developing a revised full assessment of need and compatibility assessment for each resident 31.10.2019</p>	

Regulation 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection: The Designated Centre has clear Policy and Procedures regarding the Safeguarding and Protection of Adults at Risk in line with the HSE 2014 National Policy. Staff are fully trained in this policy and procedures. There are allocated Designated Officers within the Centre to ensure compliance and development of safeguarding plans where necessary. Where safeguarding plans are implemented staff are made aware of the plan and required to read and sign the plan. The PIC will ensure that all safeguarding plans are fully documented in the residents' support plans, identifying the supports required to safeguard the residents. All staff will sign off on the relevant support plans, to advise that they have read and fully understand the safeguarding plans and their implementation. The PIC will ensure all plans are monitored within the daily management and oversight processes. The safeguarding plans are a standard item on the monthly house meeting agendas 05.07.2019.</p>	

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 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	05/07/2019
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Red	31/12/2019
Regulation 15(1)	The registered provider shall ensure that the	Not Compliant	Orange	31/08/2019

	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.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	05/07/2019
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Red	31/05/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	05/07/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/10/2019
Regulation	The registered	Not Compliant	Red	01/06/2019

17(1)(c)	provider shall ensure the premises of the designated centre are clean and suitably decorated.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	05/07/2019
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	Red	30/08/2019
Regulation 23(1)(f)	The registered provider shall ensure that that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Not Compliant	Orange	05/07/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in	Not Compliant	Orange	05/07/2019

	place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	16/05/2019
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 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.	Substantially Compliant	Yellow	05/07/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for	Substantially Compliant	Yellow	05/07/2019

	his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	31/10/2019
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	05/07/2019
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	05/07/2019
Regulation	The person in	Not Compliant	Orange	

06(2)(b)	charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.			
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	31/10/2019
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	31/10/2019
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/08/2019

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/08/2019
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