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:	Lissadell
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	11 February 2019
Centre ID:	OSV-0001897
Fieldwork ID:	MON-0024114

About the designated centre

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

Lissadell is a designated centre located in the suburbs of Kilkenny and within easy walking distance of the local amenities. Lissadell can provide residential care to five residents over the age of 18. The centre provides supports to residents with a severe to profound intellectual disability and co-existing physical and mental health diagnoses. Some residents supported in Lissadell present with behaviours that challenge. This is a high support centre which is divided into five apartments. The service operates on a 24 hour, seven days a week basis with staff present within the centre both day and night to support residents.

The following information outlines some additional data on this centre.

Current registration end date:	14/05/2021
Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
11 February 2019	09:30hrs to 17:30hrs	Laura O'Sullivan	Lead
11 February 2019	09:30hrs to 17:30hrs	Tanya Brady	Support

Views of people who use the service

The inspectors met one resident during the inspection ensuring not to cause any disruption to their planned activities. Another resident declined to meet with inspectors and this was respected. The resident that inspectors met was unable to tell inspectors about the care and support they received, however inspectors observed that they appeared both relaxed and comfortable at the centre as well as with the support they received from staff. The resident was observed to use some single Lámh (a manual signing system) signs and these were understood by the staff working with the residents.

Capacity and capability

The inspectors reviewed the capacity and capability of the centre and found that the current operational and centre level monitoring systems required review. This was found to be necessary to ensure the service provided was both safe and effective to meet the assessed needs of the residents. Whilst the provider had ensured that staffing levels had increased to improve the quality of life, guidance for staff required further review to ensure that staff were facilitated with the knowledge and guidance to support the residents in a holistic manner in line with best practice. Whilst the provider had ensured the development of polices required, the majority of these had not been reviewed since 2017. These required review to ensure staff were supported to carry out their role in an effective manner.

The registered provider had appointed a clear governance structure to the centre. A person in charge reported to the senior management of the organisation. At the time of the inspection a person participating in management had not been appointed to the centre. The senior management did provide information relating to the centre to the board of directors of the centre.

The registered provider had not ensured effective systems were in place for the organisational oversight of the centre. Despite the development of an organisational audit schedule to ensure oversight of service provision,this had not been implemented annual review of service provision or an unannounced visit to the centre had not been implemented. Due to lack of oversight and management systems the inspectors could not be assured that the provider had an awareness if the service provided was safe and effective. Systems were not in place to identify areas requiring attention or systems were not in place to improve upon the service to improve the quality of life of the residents.

Where the provider had self identified issues or concerns through

the implementation of audits, action plans were not consistently developed to ensure that actions required were addressed in a timely manner. For example, in November 2018 the provider had self-identified the need to monitor residents finances following implementation of personal file audits. A subsequent personal file audit completed in February 2019 showed that these actions remained outstanding with no action plan in place to address the ongoing issue such as daily and nightly checks of finances were not occurring consistently, there was no inventory of personal possessions.

The registered provider has appointed a person in charge to the centre. This person did possess the knowledge, skills and experience to fulfill their role, however to due to the governance remit currently assigned to the person in charge within the organisation in person participating in management roles, effective systems were not in place to ensure effective governance and operational management systems were in place. Whilst a number of roles and responsibilities had been delegated to team leaders appointed to the centre, a number of centre level monitoring systems were incomplete for example financial audits had not been completed in line with organisational audit schedule. The person in charge did not possess an oversight in the needs of the centre to ensure the service provided was effective and that action was put in place to improve the service being provided. This included consultation relating to notification of incidents to the authority.

Improvements were required to ensure that residents were facilitated and supported to raise a complaint or a concern. A number of organisational polices relating to the complaints procedure were present in the centre on the day of inspection. It was not clear which policy was the most up to date and which policy was operational. The details of the complaints officer which was on display in the individual apartments also required review. This information was inaccurate and did not provide contact details of the current personnel assigned to the role of complaints officer. Due to discrepancies in guidance and documentation relating to the complaints procedure it was not clear if staff and residents were aware of procedures to adhere to should a complaint arise.

The registered provider had carried out a review of staffing levels since the last inspection and had ensured that adequate staffing levels were in place within the centre. An additional staff member was in place at identified times during the day to facilitate participation in meaningful activities for residents. This had ensured an improvement in the quality of life of residents. Regular team meetings occurred which staff were facilitated to raise concerns relating to the operations within the centre. Team leaders had the delegated role of completing formal supervision meetings with organisational staff. However, no system was in place for the formal supervision of agency staff to ensure their role was completed to a high standard or that issues relating to work practices could be discussed. This required review.

Regulation 14: Persons in charge

The registered provider had ensured the appointment of a suitably qualified individual to the role of person in charge.

However, this role required review to ensure that systems were in place to ensure the effective delivery of care and administration of the centre given their current governance role within the organisation.

Judgment: Substantially compliant

Regulation 15: Staffing

The registered provider had ensured the number, qualifications and skill of staff was appropriate to the number and needs of the residents. An actual and planned staff rota was in place and properly maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were required with respect to supervision to ensure that all staff providing care and support to residents were appropriately supervised.

Not all staff had access to refresher training as part of their continuous professional development.

Judgment: Substantially compliant

Regulation 23: Governance and management

Managements systems within the centre were not effective in ensuring the at the service provided was safe and appropriate to the needs of the residents. Measures were not in place to ensure the implementation of an annual review of service which would incorporate the views of residents. An un-announced visit to the centre had also not been implemented.

Whilst an organisational audit schedule had been developed to ensure oversight of service provision at centre level this schedule had not been adhered to.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider prepared in writing a statement of purpose containing the information set out in schedule 1.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure within the centre required review to ensure that guidance was available to support and facilitate residents to submit a complaint to the correct individual should they wish. This guidance should also be available to ensure staff were aware of procedures to adhere to should a complaint arise.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Whilst the registered provider had ensured the development of Schedule 5 polices and procedures. However, a number of these polices required review since 2017 to ensure staff were provided with guidance on best practice and procedures ot adhere to whilst supporting residents.

Judgment: Not compliant

Quality and safety

The inspectors reviewed the quality and safety of the service being provided to the residents and found good practice in a number of areas. Since the last inspection residents had set social goals and were supported to achieve these which enhanced their quality of life, one resident was engaging in increased physical activities which staff facilitated. The inspectors observed that residents were treated in a respectful manner by staff. While some efforts on a one to one basis were made to consult with residents in relation to the day to day planning for their own apartments no residents meetings were arranged. Improvements were required however in some

of the regulations inspected against to ensure regulatory compliance.

This centre is actively following a de-congregation plan and is scheduled to de-congregated by the 31 July 2019. On the day of inspection one resident moved to a new home. However, for the four remaining residents within the centre there was no clear evidence of consultation with individuals into decisions regarding the centre or with regard to their transition plans. The provider had written to some residents regarding the de-congregation plan and the person in charge reported that the contents of the letter had been explained to some residents but not all. While it was clear that the resident who moved on the day of the inspection had access to a social story and supports to help with their transition to another centre, inspectors were not assured that any transition supports or discussions had taken place with other residents

It was observed that some apartments had some positive improvements in personalisation such as jigsaws completed by a resident framed and on display. Most apartments additionally now had improved kitchen facilities which allowed residents to be supported by staff in meal planning and preparation of food. One resident's meals were provided from the main kitchen due to an identified risk, however the rationale for this was not evidenced and required review. While improvements were noticeable, the premises were still institutional in presentation and some areas were not in a state of good repair. Certain areas required cleaning and improved storage such as bathrooms to achieve good standards of hygiene. The external areas required maintenance such as removal of obsolete furniture and discarded items.

The person in charge had ensured that individualised personal plans were in place which reflected the input of the residents, relevant members of the multidisciplinary team and staff. However these required updating to ensure they were effective and reflected the current assessed needs of the individual, in some cases personal plans had not been reviewed in two years. There was no evidence that the individuals had access to their plans in an accessible format. The inspectors noted that the registered provider had recognised the need to support residents to engage in meaningful activities and staff were observed to accompany a resident on a walk or in lunch preparation.

The registered provider and person in charge promote a positive approach in responding to behaviours that challenge and ensured evidence based and specialist and therapeutic interventions were implemented. Residents' positive behaviour support plans clearly guided staff practice in supporting residents to manage their behaviour and these plans had been reviewed within the last six months. Through the development of individualised behaviour support plans and staff training there was a reduction in behaviours that challenge and increase in the quality of life and safety of residents.

Where restrictive practices were utilised, this was done to promote the safety and well being of individuals. However, whilst there was a number of restrictions in place in the centre such as locking of the garden gate, recording and monitoring of these was not consistent and on resident files did not contain clear details on restrictions

assessed as required and in use for individuals. This was actively being addressed by the team leader with review of documentation in progress to ensure clear guidance was available for staff with respect to rationale for the use of all restrictions and procedures to adhere to.

Overall, the provider had systems in place to protect residents from abuse.
The registered provider had ensured that safeguarding plans were in place for all residents as required and that these were reviewed in a timely manner with actions completed as identified. Where an allegation had arisen or a concern was present there evidence of adherence to national safeguarding policy. An organisational policy was also in place which provided guidance for staff on procedures to adhere to in conjunction with staff training.

The arrangements in place for the assessment, management and ongoing review of risk were not implemented to an effective level by the provider. The inspectors found that the risk register in the centre was incomplete and did not contain all identified risks present in the centre, as an example, no risk assessment in place for lone working to guide best practice and supports for staff. The risk register was not reviewed by the person in charge within the agreed time frames for the risks that were identified. The inspectors noted that individual risks while identified such as choking risks, were not present in personal files and as a result not shared with staff.

Regulation 17: Premises

The premises are not designed and laid out to meet the needs of the residents. A number of areas require maintenance and repair.

Judgment: Not compliant

Regulation 18: Food and nutrition

The person in charge has ensured that staff have appropriate knowledge, skills and competence to ensure the food and nutritional needs of residents are met. Fresh food was present in the centre and residents now have the facilities to prepare meals and snacks if they wish to.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Residents were scheduled to transition to new centres. There was no evidence that this transition decision had been carried out in consultation with each resident. It was not evident that residents were provided with training in life skills that may be required or provided with information on the transition plan.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that effective systems were in place for the identification and ongoing review of risk within the centre. Risks that had been identified had not been addressed within individualised and/or centre risk registers.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place. There was evidence that these plans were informed by assessment and there was evidence of multidisciplinary assessment. Residents had individualised goals however, improvement was required in reviewing support plans to ensure they were effective.

Judgment: Substantially compliant

Regulation 8: Protection

Overall, the registered provider ensured policies and supporting procedures were implemented to ensure residents were protected from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were well supported to make choices on a day to day basis for their individual apartments. Residents were not afforded the opportunity to participate in and consent to supports where necessary and to making decisions about their lives.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Positive behavioural support guidelines were in place with clear documented information available to support staff. There was evidence that these support guidelines were actively reviewed.

The use of restrictive practice was in place to promote the safety of residents. Improvements were required in relation to the documentation of these practices.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Lissadell OSV-0001897

Inspection ID: MON-0024114

Date of inspection: 11/02/2019

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 14: Persons in charge</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 14: Persons in charge:
The Operations team have reviewed the arrangements for the post of Person in Charge in the designated centre to release the Community Service Manager from the role of PIC.

The current Team Leader was identified to match the profile of the supported people in the designated centre Lissadell. She also has the right qualifications and skill mix to meet the needs of the 4 men supported in Lissadell. The Team Leader has shown great ability to improve the quality of life for the people supported in the designated centre.

Documentation relating to the registration of a new PIC in the designated centre will be submitted to the authority for consideration latest by the 19/04/2019.

The Community Service Manager will then be released from the position as PIC and is providing support for the new PIC within the cluster model and as PPIM for the designated centre.</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Employees are supported to attend mandatory and mandated training/courses. It is also the responsibility of employees to propose training that would enhance and support their role within St. Patrick's Centre (Kilkenny).</td></tr>
</table>

A centre specific training profile, individual employee training profiles and a training schedule are distributed monthly to the PIC and CSM of the centre by the Training Department. Employee training is on the agenda of the monthly team meetings.

Training Update:
- All employees have completed Studio 3 (managing challenging behaviours) training by the end of March 2019. The Team Leader will ensure that employees will be booked in for refresher training as necessary.
- Employees are booked in for Lamh training (09/04/2019), Safeguarding training (11/04/2019), Keyworker training (18/04/2019), First Aid training (23/04/2019), Epilepsy training (07/05/2019) and Manual handling training (15/05/2019).

The PIC has a schedule for the 6 weekly Quality Conversations with the employees in the designated centre in place to ensure continuous development.
The Quality Conversations policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for employees. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

To ensure all management staff has the necessary skills to provide Quality Conversations of high standard, the HR Manager is in the process of developing Supervision training for all management staff within St. Patrick's Centre (Kilkenny). This training for behavioural competences/quality conversations will be rolled out for all management staff during the month of April 2019.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The management structure within the designated centre was reviewed. To ensure clear lines of authority and accountability until the new PIC is registered there is now only one Team Leader in place to support the PIC.

The PIC and Team Leader have developed a weekly management oversight schedule to ensure delegated duties and actions are documented and followed up.

St. Patrick's Centre (Kilkenny) audit schedule is in place and used to monitor optimal quality of services to the people we support. This schedule is available in the office of Lissadell to guide the Team Leader around the auditing process. The Team Leader has also developed a checklist to ensure follow up on audits is being carried out. These audits will create action plans and delegated duties for the staff team.

An annual provider audit was completed in March 2019. The PIC and Team Leader met on the 11/03/2019 to discuss the outcome and actions of the provider audit.

To ensure that provider audits are completed in line with the regulations the Director of Service has scheduled training on the 04/04/2019 for the Community Service Managers, Project Officers and the Quality Department. This training will facilitate knowledge transfer between staff who is completing provider audits and build capacity to ensure provider audits are completed in line with the regulations and include input from people supported and/or representatives.

The Team Leader is introducing the Questionnaire for residents (HIQA guidance document) to support staff and people supported in team and residents meetings to ensure people supported's voice about the service being provided is captured.

A customer satisfaction survey has been developed within St. Patrick's Centre (Kilkenny). The link to the survey was circulated to all people supported and their Team Leaders on the 01/04/2019 via email. The Team Leader will ensure that keyworkers are supporting the people to complete the survey.

The survey will also be distributed to the representatives of all people supported and staff on 01/05/2019.
Going forward St. Patrick's Centre (Kilkenny) will distribute the customer satisfaction survey every year on the 1st April to all people supported, their representatives and staff.

Effective arrangements are in place to support, develop and performance manage all members of the workforce. Within Quality Conversations any issues of performance are identified, recorded and communicated with staff and plans are put in place to build capacity (e.g. training, coaching, action analysis). The Team Leader has a scheduled monthly meeting with his HR Partner to discuss all performance management issues.

The PIC has delegated the completion of Quality Conversations for staff in Lissadell to the Team Leader. A schedule for all Quality Conversations is visible for all staff in the office of Lissadell.

To ensure all management staff has the necessary skills to provide Quality Conversations of high standard, the HR Manager is in the process of developing Supervision training for all management staff within St. Patrick's Centre (Kilkenny). This training for behavioural competences/quality conversations will be rolled out for all management staff during the month of April 2019.

Regulation 34: Complaints procedure	Substantially Compliant

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

The complaints easy read document and complaints poster were updated for the designated centre Lissadell immediately after the inspection took place to reflect the PIC and Team leader. The easy read document and complaints poster are available in the office and also in each apartment for staff and the people supported.

The Team Leader has an agenda for the weekly residents meetings in place. The complaints procedure is now part of the agenda of residents meetings, facilitated with the easy read policy document and other visuals.

The Team Leader has included safeguarding and complaints also on the agenda for the monthly team meetings within the designated centre.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A new Quality and Therapeutic Manager started with St. Patrick's Centre (Kilkenny) on the 04/03/2019.
One of her priorities is the review and update of all schedule 5 policies, which is already in process. A schedule, outlining the working groups and expected date of completion will be available for the inspector on the 01/05/2019.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
On the day of the inspection the inspector found that food preparation for one person supported in his apartment is limited due to the kitchen facilities provided in the apartment on the premises.
The Team Leader and staff team are providing a range of cooking facilities to ensure that the person supported can avail of a balanced diet and meal preparation. A slow cooker, a grill and a sandwich maker are available in the kitchen to do so.

The Team Leader requested a deep clean to be carried out in all apartments of Lissadell, which was completed on the 23/02/2019. One household maintenance staff is now assigned to the designated centre one day per week to ensure the cleanliness of the apartments for the people supported.

The Team Leader has contacted the maintenance team to ensure all the removal of

obsolete furniture and discarded items. This was completed on the 12/02/2019.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
On the day of inspection the inspector found that there was no evidence on people supported's files regarding the consultation of people supported to their future community homes.

To clarify how people supported are involved in the transition process please find the following actions:

• In 2016 and 2017 the Community Transition Coordinators completed the 'my home – my whises' document with each person supported within St. Patrick's Centre (Kilkenny). Housing needs and person supported's wishes and preferences were identified to ensure a suitable community home can be located and the compatibility of people supported living together going forward.

• Weekly de-congregation meetings are held within St. Patrick's Centre (Kilkenny) between the Director of Service, Finance Manager, Housing Manager, Practice Development Manager, the Community Service Managers, Quality Department and Community Transition Coordinators to discuss possible living arrangements for people supported on basis of the identified needs and wishes.

Within this meeting discussions are around locating suitable premises and compatibility of people supported in relation to their identified support needs and personal interests.

• As soon as a house is identified for a person supported as a suitable future community home the Community Service Manager, PIC and Community Transition Coordinator are starting the transition process.

An email is sent to every person supported, informing them about the identified premises and giving advise on how transition process will be moving forward.
Transition documentation for the transition process is available in each person supported's file.

• Resident's will be notified at their weekly residents meeting of any updates through a social story, easy read transition plan?

After the carried out inspection the process of the involvement of people supported was discussed and reviewed in the de-congregation meeting on 12/02/2019.
As a result the monthly review meeting template (as per MDT pathway) was amended

and has now included a transition section. They keyworker and person supported are now able to get a monthly update regarding the transition plan which will be documented in the monthly review of each person supported.

The PIC and Team Leader have discussed skills teaching for all people supported in Lissadell to ensure all men are supported in learning new tasks and also prepared for the transition to their community home.
The Team Leader is currently supporting the staff team to complete the 'skill learning template' with each person supported to ensure learning steps are documented. The monitoring of the 'skill learning template' will be completed through Quality Conversations with the keyworker.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The review of the risk register of Lissadell was completed immediately after the inspection took place. An up to date risk register is now in place for the designated centre.

The Team Leader and staff team are in the process of reviewing all person supported's risk assessments and Standard Operating Procedures in Lissadell.

The PIC and delegated staff will review and monitor all risk assessments on a three monthly basis or immediately where required.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All people supprted's files and documentation were audited. The audit tools have action plans included, which are completed by the staff team and followed up by the Team Leader to ensure all person supported's documentation (personal plans, communication passports,…) is up to date.
The review and update of all person supported's files will be completed by the 30/05/2019.

Goals were identified for all people supported through their visioning process. The Team Leader is currently supporting keyworkers to review and update the goals and develop activities with each person supported to work towards achieving these goals. Development will be documented on the person supported's visioning template and on the conditions for success forms which are reviewed between the Team Leader and keyworker in Quality Conversations.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Team Leader has developed a schedule and an agenda for weekly residents meetings within the designated centre. Since the 15th March 2019 weekly residents meetings are held in the designated centre Lissadell. The Questionnaire for residents (HIQA guidance document) was introduced by the Team Leader to ensure people supported's voice about the service being provided is captured.	

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Substantially Compliant	Yellow	19/04/2019
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.	Substantially Compliant	Yellow	15/05/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	30/04/2019

	are appropriately supervised.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	05/04/2019
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	20/02/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	20/02/2019
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	05/04/2019
Regulation 23(1)(d)	The registered provider shall ensure that there	Not Compliant	Orange	11/03/2019

	is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	11/03/2019
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.	Not Compliant	Orange	07/03/2019
Regulation	The person in	Not Compliant	Orange	15/04/2019

25(3)(b)	charge shall ensure that residents receive support as they transition between residential services or leave residential services through:where appropriate, the provision of training in the life-skills required for the new living arrangement.			
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	20/02/2019
Regulation 34(1)(b)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall make each resident and their family aware of the complaints procedure as soon as is practicable after admission.	Substantially Compliant	Yellow	15/02/2019
Regulation	The registered	Substantially	Yellow	15/02/2019

34(1)(d)	provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Compliant		
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	20/02/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	01/05/2019
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where	Substantially Compliant	Yellow	15/04/2019

	appropriate, his or her representative.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	30/05/2019
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/05/2019
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more	Substantially Compliant	Yellow	30/05/2019

	frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/05/2019
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	15/03/2019