Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Glebe Lodge
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	24 June 2022
Centre ID:	OSV-0001966
Fieldwork ID:	MON-0035973

About the designated centre

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

Glebe Lodge is operated from a large purpose built bungalow located on the outskirts of a small town. The centre can provide full-time residential support and some respite for up to eleven residents of both genders over the age of 18. The centre is intended to support residents with intellectual disabilities and those with high support needs related to aging. Support to residents is to be given by the person in charge, team leads, nurses, care assistants and catering staff. Within the centre there are eleven individual bedrooms for residents in addition to lounges, a kitchen/dining area, bathrooms and staff offices.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 24 June 2022	09:35hrs to 19:00hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Staff members on duty were seen to support and interact with residents appropriately. Some areas were identified where aspects of the premises provided for residents to live in could be improved upon.

At the time of this inspection, 11 residents were present in this centre. Ten of these residents lived full-time in the centre while one resident was attending the centre on respite using the centre's one dedicated respite bedroom. In total the inspector met seven of the residents present during the inspection. Most residents did not engage verbally with the inspector but one asked the inspector where they were from while another resident talked about the weather, attending their day services and listening to music on the radio. A third resident indicated to the inspector that they liked living in the centre.

Staff members on duty supporting the residents were seen and overheard to engage with them in a pleasant, warm and respectful manner throughout the inspection. For example, a staff member was seen to knock on a residents' bedroom door before entering while multiple times during the inspection staff members were seen to engage with residents at eye level and in an unhurried manner when providing supports to the residents. It was indicated to the inspector though that at night all residents were checked on an hourly basis with one staff member suggesting that most residents did not need such checks.

The atmosphere in the centre on the day of inspection was generally found to be calm and sociable. Some residents appeared happy when the inspector greeted them. For example, one resident smiled at the inspector as the resident sat watching television. While none of the residents were observed to leave the centre to go an outing or activity during the inspection, some residents were seen to be taken for a short walk around the grounds of the centre while other residents were observed to do some art work. Some residents also took part in a virtual game of bingo which one resident in particular seemed to enjoy.

As the residents did not leave the centre during the day, the residents spent time in their bedrooms or the centre's communal areas. It was seen that the premises provided for residents to live in was generally homelike, clean and well furnished. For example, there was numerous photographs of residents on display in the centre. The inspector did note though some areas of the centre where maintenance was required. For example, in a laundry room it was seen that a part of the flooring was missing while some tiles were also missing from a sluice room. The inspector was informed that maintenance works including painting was due to be carried out in the centre.

The door between this sluice room and laundry had signs on either side of it indicating that it was to be kept closed for infection prevention and control purposes. Despite this shortly after the inspection commenced the inspector

observed that this door had been left open. It was unclear how long it had been open for. This matter was highlighted to the person in charge and this door was seen to be closed for the remainder of the inspection. The premises was provided with fire doors which help contain the spread of fire and smoke but despite this the inspector did also observed one fire door being held open by a door stop early into the inspection which would negate it effectiveness as a fire door. The same door was later seen to be closed fully.

When reviewing the premises provided the inspector noted some white powder in one hall and also in the bedroom of one resident. Upon querying what this was and what it was for, the inspector was informed that this was ant poison which was used in response to some ants gaining access to the premises. It was also indicted that that the provider was engaging with an appropriate external company in response to this matter. The inspector did not observe any ants present in the centre on the day of inspection.

In summary, aspects of the premises provided for residents to live in required improvement particularly from a maintenance perspective. Staff members on duty were seen and overheard to support residents in a pleasant, warm and respectful manner throughout this inspection.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The overall governance and management arrangements for this centre were not ensuring compliance with the relevant regulations. Staffing arrangements and staff supervisions were also areas which required improvement.

This designated centre was last inspected by HIQA in August 2021. At the time of that inspection the centre did not have a dedicated onsite centre manager who would ordinarily serve as person in charge for the centre. As a result a member of the provider's senior management had been appointed to the role of person in charge for the centre. However, this person also held a wider role with the provider and was based elsewhere which meant that they were not focused solely on this designated centre as the centre manager would normally be. The August 2021 inspection found that the absence of a dedicated centre manager was having a negative impact on compliance with the regulations particularly from an administration perspective, oversight at a local level and the supervision of staff.

Since that time the same person in charge had been appointed to a similar role for another of the provider's other designated centres while retaining their pre-existing remit and responsibilities. In response to such matters HIQA received a governance

and management plan form the provider in February 2022 which applied to this centre. In this the provider outlined the measures they were taking to ensure effective oversight of this designated centre. Such measures included appointing a team lead for this centre to support its operations, providing bi-monthly supervision for this team lead and conducting an audit of governance and management after three months. The purpose of the current inspection was to assess progress with this governance and management plan as well as assessing the supports provided to residents.

It was found that the provider had completed some of the actions in the governance and management plan with two team leads having been appointed. However, some of the actions such as an audit of governance and management and bi-monthly supervision for the team leads had not been completed. In addition, there remained clear indications that the management arrangements for this centre were not ensuring effective oversight of the centre which was impacting compliance levels with relevant regulations. In particular, it was noted that a number of requirements, which under the regulations are the direct responsibility of the person in charge, were not been adequately discharged.

For example, while it was initially indicated to the inspector that all staff supervisions were up-to-date, four staff members spoken with during this inspection indicated that they had not been supervised in some time. Such findings did not provide assurances that the remit of the appointed person in charge was ensuring effective administration and operational management of this centre. As discussed elsewhere in this report, a number of regulatory actions were identified on this inspection which also did not provide assurance that the provider's overall monitoring systems were ensuring that the services provided to residents were appropriate to residents' needs, consistent and effectively monitored. In particular, it was found on this inspection that the staffing arrangements in place were not in keeping with the needs of all current residents.

The August 2021 inspection had highlighted that additional staff supports had been sought to support residents but since then the needs of some residents had increased while some residents also required high levels of staff support for certain activities. The inspector was informed that additional staff supports had again been sought to support residents but were not yet in place. There were indications that the current staffing arrangements were impacting the operations of the centre. For example, when reviewing incidents records in the centre, the inspector read one incident whereby a restrictive practice was used for one resident in a manner other than it was approved for. The restrictive practice was used in this way because staff were unable to supervise the resident while attending to others residents. While the inspector only read one incident report about such an occurrence, he was informed by a staff member that it had happened more than once.

Regulation 14: Persons in charge

The current person in charge arrangements were not ensuring effective governance, operational management and administration of the current centre.

Judgment: Not compliant

Regulation 15: Staffing

The staffing arrangements in place for the centre at the time of inspection were not in keeping with the needs of residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Not all staff working in this centre were being appropriately supervised.

Judgment: Not compliant

Regulation 23: Governance and management

A number of regulatory actions were identified on this inspection. The provider had not implemented all of their stated actions in a governance and management plan previously submitted to HIQA. The provider's monitoring systems were not ensuring that services provided in this centre was appropriate to residents' needs, consistent and appropriately monitored.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

While residents had contracts for the provisions of services provided for, the same review by the inspector did not set out the fees residents were to pay, one contact did not indicate how many night a resident availed of when in the centre while one had not been signed by a representative of the provider to indicate that the contract was agreed.

Judgment: Not compliant

Regulation 31: Notification of incidents

A medicines related incident which had safeguarding implications had not been notified to HIQA.

Judgment: Not compliant

Quality and safety

While staff spoken with demonstrated a good knowledge of the residents they were supporting, improvements were identified on this inspection in areas such as medicines, infection prevention and control and aspects of personal planning.

Throughout this inspection staff were seen to wear appropriate personal protective equipment (PPE). Supplies of PPE were maintained in the centre and while some of these had passed their expiry date, most were seen to be in date. Supplies of hand sanitising products were also present in the centre. Given the ongoing COVID-19 pandemic it was seen that he centre had a COVID-19 contingency plan while a relevant self-assessment on infection prevention and control had been recently completed. All staff working in this centre had also completed training in the area of infection prevention and control. It was indicated to the inspector though that all staff were to check and record their temperatures twice while on shift but when reviewing records related to this, a number of instances were seen where staff only recorded their temperatures once.

In addition, the inspector was informed that the centre did not have a dedicated cleaning staff in place but was in the process of recruiting one at the time of inspection. In the interim it was indicated that other staff were conducting cleaning in the centre. However, when reviewing the cleaning record provided no cleaning was indicated as having been conducted throughout June 2022 while some gaps in the cleaning records before then were also noted. This did not provide assurance that cleaning was being carried out on a consistent basis in accordance with infection prevention and control standards although, as highlighted earlier, the overall premises was seen to be clean on the day of inspection.

The premises was provided with facilities for the storage of medicines but it was seen that aspects of the storage arrangements in place required review to ensure security. For example, during the inspection it was observed that a trolley used to store medicines was kept in an unlocked room and the trolley was not securely fastened to a wall when not in use. A sample of medicines documents for residents were also reviewed and, while they were generally found to be of a good standard,

it was seen that some did not include a resident photograph while one relevant record did not indicate if a resident had any medicine sensitivities or not. It was found though that residents were being assessed to determine if they could administer their own medicines.

Within the centre, a systems was in place for any medicine related incidents to be recorded and reviewed. When reviewing one such incident record the inspector identified one instance where a resident had not received a prescribed daily medicine for a period of six days which resulted in a negative outcome for the resident involved. While this matter was reviewed upon being identified with some follow actions taken in response, the nature of this incident did have some safeguarding implications. Despite this safeguarding procedures had not been enacted for this incident nor had had HIQA been notified of this incident. It was seen though that the provider had responded appropriately to other safeguarding concerns with relevant referrals made and safeguarding plans put in place where necessary.

Residents had a number of specific care plans contained within their individual personal plans. Such plans are required by the regulations and should reflect the assessed needs of residents. The inspector reviewed a sample of these plans and noted a clear assessment process with care plans put in place where it was identified that a resident had a particular health, personal or social need. It was noted though the personal plan of a resident who had recently moved into the centre had not been completed in full while the resident had not yet had an opportunity to be involved in their personal plan via a person-centred planning meeting although the inspector was informed that such a meeting was scheduled. Another resident had recently had such a meeting where goals were identified for the resident to achieve. It was noted that responsibilities nor timeframes for supporting the resident achieve these goals had been identified. The inspector was also informed that most residents of the centre did not have an easy-to-read version of their personal plans.

Included amongst residents' personal plans was information on how to support residents with their health needs. When reviewing one resident's wound care management plan, it was noted that it lacked detail in some areas and did not specify how often the resident was to be repositioned in response to the particular needs of that resident. Other records reviewed did indicate that this resident was being repositioned regularly but the frequency between such changes was seen to vary on occasions while on one particular day there was a gap in the records provided. It was also noted that there was some inconsistencies in the monitoring records used for this resident and their wound care. Before the close of inspection, the inspector was informed that a new monitoring template was being used going forward.

When reviewing other records, it was indicted that one resident was to undergo particular exercises multiple times during the day. A monitoring sheet provided indicated that a staff member had signed as completing these exercises most days. However, the inspector did note some recent days where no entry was made while the entry on another day suggested the exercises had been completed once only.

Another resident also had documentation in their personal plan which suggested that they too should have been undergoing exercises as recommended by a physiotherapist. The inspector was informed though that the resident was not currently receiving these exercises and that the exercises had been recommended by a physiotherapist in a different setting. Despite this the inspector was also informed that the resident had not been assessed by a physiotherapist since moving to this centre.

While such areas required improvement, there were indications that health needs of residents were being supported in other ways. For example, records reviewed indicated that residents had health assessments completed by a general practitioner and were also supported to access other health and social care professionals such as neurologists and speech and language therapists. Residents also had hospital passports in place which outlined key information and their medical history in the event that they required to be admitted to hospital. The staff members spoken with throughout this inspection also demonstrated a very strong knowledge of the residents' needs while outlining the actions they would take to support the needs of residents.

Regulation 17: Premises

Some areas of the premises which required maintenance were seen during this inspection while the house also had issues with ants.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A systems for recording incidents was in place. Various risk assessments were in place that had been recently reviewed but a particular risk related to one resident had not been specifically assessed. When reviewing incident records, two instances incidents of a similar nature were recorded for the same resident. While the inspector was informed that a relevant risk assessment had been started, no record of this was provided on the day of inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

No clean records were provided for the centre for the month of June 2022. There

were gaps in staff temperature checks. Some expired PPE was present in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

A fire door was briefly observed to be held open. While a night time fire drill had been stimulated to the previous inspection, a further one was required given an increase in the number of residents living in the centre.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

One resident had not received a prescribed daily medicine over a period of time which had a negative impact on the resident. Storage arrangements for medicines required improvements. Some medicines documents also required review to ensure they contained all relevant information.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

One resident's personal plan had not been completed in full while the resident had not yet had an opportunity to be involved in their personal plan via a person-centred planning meeting. Goals identified for one resident did not set out time frames nor responsibilities for helping the resident achieve these goals. A wound care management plan required further details. Most residents did not have easy-to-read versions of their personal plans.

Judgment: Not compliant

Regulation 6: Health care

Gaps were noted in exercise records for one resident while another resident had not been assessed by physiotherapist despite some documentation suggesting that they too should have been receiving particular exercises.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A restrictive practice had been used for purposes other than the purpose it had been approved for.

Judgment: Substantially compliant

Regulation 8: Protection

A medicines related incident which had safeguarding implications had not had safeguarding procedures enacted.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were being checked hourly at night but it was suggested that most residents did not need such checks. This had the potential to impact residents' privacy.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Glebe Lodge OSV-0001966

Inspection ID: MON-0035973

Date of inspection: 24/06/2022

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
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A current staff in Glebe lodge has expressed an interest in the role of PIC in Glebe lodge on a part time permanent (19.5hrs) basis. The remaining 19.5 position has been advertised, there was one applicant who was offered an interview but did not attend for same. The staff that was initially interested in the 19.5 PIC role is now considering the fulltime position, there is also a team lead who has been asked to consider remaining in the position permanently with the support of the fulltime PIC. Funding has been secured to ensure that the fulltime hours are off the roster for the PIC and are dedicated to ensuring compliance with the regulations, particularly from an administrative perspective, oversight at local level and the supervision of staff. The current Acting PIC will update HIQA as soon as she receives a response in relation to the above. In the interim the 2 team leads will remain in place and the acting PIC will remain in place The CNS is committed to spend 1 day a week in the DC, this will support the team leads and will give further oversight.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A meeting was held with the DOS and the A/disability manager on 18/07/22, where the staffing issues have been outlined. A meeting with the A/Disability manager General manager the DOS and ADOS took place on 20/07/22 where all our funding concerns were again raised, no commitment to funding was assured In the interim the association has put in place some evening hours to support the needs of the residents in the DC. The association has completed a risk assessment and has approved hours that are critical to support the needs of the residents.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Some additional supervision of staff has occurred since the inspection, both team leads have had supervision and this is scheduled again for 2 weeks' time and will continue on a fortnightly basis. Supervision for outstanding staff will be completed by the end of August 22.
Specific one day training will be rolled out for staff which will address, safeguarding, notification of incidents, the importance of the complaints procedures and goal setting.
Staff nurses must complete medication training on HSELand

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Supervision of staff is progressing and will be completed by the end of August 22. Team leads will be supervised fortnightly, first supervision of team leads has commenced.
Team leads are submitting weekly reports to the senior team which is discussed and actioned at the weekly operations meetings. KPFA governance and management plan will be completed on a monthly basis and updated on a monthly basis. The CNS will complete audits on medication management and healthcare plans 6 monthly. The provider audits will be increased to quarterly until such time as a permanent PIC is appointed.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
All contracts of support are being reviewed and will be include all relevant information including fees for the residential placement and number of residential nights that each resident receives. All contracts of support will be signed by the service provider, residents or family representative and copies will be issued to family members.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Currently team leads in place are submitting weekly reports to the senior team, going forward all PIC`s will be asked to complete same. These will be reviewed at the weekly operations meeting, all incidents will be reviewed also at the weekly operations meeting and in collaboration with the team leads, PIC`s and the senior team it will be ensured that all required notifications will be submitted.
An NFO6 was submitted on 22/07/22 in relation to a medication incident, a PSF1 was also submitted to the Safeguarding and Protection Team which has been closed off with no grounds for further concern

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Maintenance issues are being addressed by the maintenance department, all issues identified have been approved. The issue with ants has been addressed by Rentokill and currently it is not a concern.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A specific risk discussed on the day of inspection has been assessed, completed and recorded with appropriate controls in place. A risk assessment has been completed in relation to the 2 incidents of a similar nature. The PIC will continue to monitor all risks in the DC	
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: A household attendant has commenced her post (15hrs per week) on 04/07/2022. She has a full cleaning schedule which will be adhered to. All cleaning records are being completed. Staff check their temperatures on arriving at the designated centre, a risk assessment has been completed to support once daily temperature checks All expired PPE has been disposed of. Staff have been reminded that the sluice room door must remain closed to support IP&C.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A night time drill is scheduled for 29/07/22 which will simulate and take into account increased capacity in the DC. A magnetic door release system will be put in place where the fire door was being held open	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: A requisition was submitted to secure the medication trolley to the wall. The maintenance man called to the DC on 20/07/22 and will purchase the materials required for same. All prescription sheets will be reviewed and passport photos will be included in all of the residents prescription sheets, any sensitivities to medications will be noted on same.	
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 personal plan for a new resident has been completed and a person centered planning meeting was held 2 weeks ago. Timeframes and responsibilities to support residents to achieve their goals have been identified and noted. A guide on goal setting from the HSE must be read and signed by all staff Easy to read care plans are being developed for all residents in the DC.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: A new monitoring system is in place to support wound care for a resident where all aspects are monitored, a new record of exercises being completed is also in place. Staff have been reminded that all records in relation to repositioning must be completed. A residents has been referred to the community physiotherapist by the GP for assessment	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Additional staff will be in place when an individual avails of respite so that the unapproved restriction will not be used going forward	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: All incidents will be reviewed and assessed at the weekly operations meeting and in collaboration with the team leads, PIC`s and the senior team it will be ensured that all required notifications will be submitted. The S&PT were contacted and discussed a medication incident, there were no grounds for concern and a PSF1 was submitted for records, the incident is closed to the S&PT, a late NFO6 was also submitted in relation to this incident	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Night time checks have been reviewed in consultation with Staff Staff felt most of residents need to be checked hourly and some can be viewed from glass panel on their door and so not entering the resident's bedrooms. A guidance document has been developed to support this . A risk assessment has been completed and this will be reviewed based on the needs of each individual	

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(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	Orange	30/10/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/09/2022

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/08/2022
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.	Substantially Compliant	Yellow	30/09/2022
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	30/10/2022
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	30/08/2022
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the	Not Compliant	Orange	30/08/2022

	resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Substantially Compliant	Yellow	30/08/2022
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.	Substantially Compliant	Yellow	30/10/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of	Not Compliant	Orange	22/07/2022

	healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/10/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	29/07/2022
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	30/08/2022
Regulation 29(4)(b)	The person in charge shall ensure that the	Not Compliant	Orange	22/07/2022

	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.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	22/07/2022
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	22/07/2022
Regulation	The person in	Substantially	Yellow	22/07/2022

05(4)(c)	charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with 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.	Compliant		
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/09/2022
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	30/08/2022
Regulation 06(1)	The registered provider shall provide appropriate health care for each	Substantially Compliant	Yellow	30/08/2022

	resident, having regard to that resident's personal plan.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	22/07/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	22/07/2022
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	22/07/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications,	Substantially Compliant	Yellow	30/07/2022

	relationships, intimate and personal care, professional consultations and personal information.			