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:	Beechhaven
Name of provider:	Co Wexford Community Workshop (Enniscorthy) CLG
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	02 May 2024
Centre ID:	OSV-0002121
Fieldwork ID:	MON-0039020

About the designated centre

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

This designated centre is a large purpose built, detached bungalow set in an elevated site on the outskirts of a busy town. It has seven bedrooms for residents, five of which are en-suite, a large and small living room, large kitchen and dining room as well as well appointed bathrooms and a well maintained outdoor space. It is located in the suburbs of a large town in Co. Wexford. Residents can access day services if they wish either on site or in other locations, and residents are also facilitated to stay in the centre if they prefer. Locally residents can access a range of local amenities such as shops, churches, restaurants, pubs, barbers, hairdressers. This centre is open on a year round seven day a week and 24 hour a day basis. Residents are supported at all times by a staff team, comprising of nurses, social care workers and healthcare assistants. The statement of purpose for the centre set out that the provider aims to "support and value residents, within a caring environment, in a manner which promotes the health, well being and holistic needs of residents. The aim is to empower residents with the necessary skills to live full and satisfying lives as equal citizens in the local community, in conjunction with their individual person centred plan". This centre is home to eight residents with varying degrees of intellectual disability and specific high support needs due to changing health and the process of aging.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Thursday 2 May 2024	10:10hrs to 17:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This was an unannounced inspection of this designated centre, completed to review the provider's compliance with the Regulations and the quality of care and support offered to residents living here. The designated centre is registered to provide full time residential care and support for up to seven residents and is located close to a town in County Wexford. Overall the findings of this inspection were, that the residents appeared happy in the centre and were engaging in activities they enjoyed both in the centre and in their local community. There were seven residents living in the centre at the time of the inspection and the inspector had the opportunity to meet and briefly engage with each of them during the inspection.

From what the inspector observed, read and was told, this was a well-run centre where residents were enjoying a good quality of life. They were supported to make decisions in relation to their day-to-day lives and to take part in activities they enjoyed. The provider was for the most part self-identifying areas where improvements were required and taking action to bring these about although some of these improvements needed to be completed in a more timely manner. In line with the findings of the provider's own audits and reviews there were a number of areas such as resident's personal possessions, fire safety, notification of incidents where improvements were required. These will be discussed further later in the report.

The centre is a large bungalow which has eight bedrooms. It has a paved area to the front, and a large hard-surface garden to the back of the house. There is a large kitchen with an area adjacent to it with dining facilities, two sitting rooms, one a large room and one 'snug', a large utility, two shared bathrooms and another toilet, seven resident bedrooms five of which are en-suite, a staff sleep-over room and a staff office. Residents' bedrooms were decorated and arranged in a way that suited them. They had their personal items on display and had storage for their personal belongings. Communal areas were bright and airy. There was outdoor seating and areas with a pergola and a fenced off run for one of the resident's pet dog. There is also a number of planters with seeds or small plants which residents had helped with planting.

There was a warm and welcoming atmosphere in the house. Residents opened the door to welcome visitors and were supported to engage with and take the lead in interactions with visitors. When the inspector arrived in the morning they were greeted by three residents one of whom opened the door. They had all met with the inspector previously and welcomed them back to their home. They were getting ready to go to their day services. All individuals who lived in this home attended formalised day services at their request. The residents told the inspector that they liked how they spent their days and knew they had the option to stay at home should they choose to.

One resident liked to walk to their day service which was located to the rear of the

centre but preferred to walk through the garden when the pet dog belonging to a peer was in their run and not loose in the garden. They were observed working with staff to arrange this. The resident asked if the inspector would play a short game of catching a ball while waiting for the dog to go into the 'run'.

Later in the day as all residents returned to the centre they came to speak with the inspector or went to relax in their rooms with others sitting together in the dining room for something to drink and eat. The staff team were familiar with residents' preferences and routines. Staff were observed to be very familiar with individual communication preferences and to pick up and respond to residents' verbal and non-verbal cues. Residents were observed to be comfortable in their home and to be content in the company of staff. Some residents told the inspector they were happy, and some used hand gestures such as a thumbs up to indicate this. Throughout the inspection, kind, caring, warm and respectful interactions were observed between residents and staff.

Residents were engaging in a wide range of activities such as taking part in choirs, going for meals or meeting friends for coffee, going to the cinema, for walks going to the gym or health spa or going on holiday. The previous weekend three residents had gone away together for a short holiday break and had really enjoyed this. One resident who had not gone told the inspector that the changes in staffing levels had meant that they did not get to go to church which is an important outing for them. This was communicated to the person in charge who spoke to the resident on the day of inspection explaining that they were sorry this had happened. Discussion with the resident on using the complaint system was facilitated. Residents could take part in cooking and baking if they wished to, and staff spoke about how much some of the residents enjoyed this. Residents could also take part in the upkeep of their home and had facilities to engage in cleaning or do their laundry if they wished to.

Residents and their representatives views were sought by the provider on an ongoing basis and their views were captured as part of the provider's annual and six monthly reviews in the centre. Residents could access information on complaints, accessing independent advocacy services, infection prevention and control and residents' rights in the an easy-to-read format. Social stories were developed as required and residents were meeting with their key workers to develop goals relating to personal development and activities. Staff were completing human rights training and the impact of this on the lived experience of residents was being reviewed.

In summary residents were keeping busy and had things to look forward to. They were being supported by a number of committed and motivated staff. The provider was aware of the areas where improvements were required and had self identified the findings in relation to the management of personal possessions for example and were working to implement changes.

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

Capacity and capability

Overall, the findings of this unannounced inspection were that the provider's systems to monitor the quality and safety of care and support were being utilised effectively in this centre. The provider was transitioning to new on-line recording systems and moving from paper records. This transition was still underway and as such the person in charge and team leader were working hard to ensure that no gaps in documentation were occurring. This transition had allowed the provider and person in charge to review systems and identify potential gaps in practice such as those relating to Regulation 12 in particular. Although a minor gap in documentation had led to a finding as outlined under Regulation 31.

The inspector found that the provider was aware of areas where improvements were required, particularly relating to the premises and fire safety however, they had been slow to implement the required actions to bring these about as reflected under Regulation 23. There was however, a clear focus on quality improvement and moving beyond compliance in this centre.

Regulation 15: Staffing

The provider had ensured that there were sufficient staff to deliver person-centred, effective and safe care to residents based on their assessed support needs. This was a provider reported improvement from 2023 when the provider had self identified that additional staff were required and they had been successful in recruitment. A number of incidents had been recorded in 2023 of the centre being short staffed and there were clear protocols in place as an outcome of these. In 2024 there were no recorded incidents of short staffing since the increase in the staff team. Staff move between the centre and the day services as a way of facilitating consistent support over the 24 hour day.

There were planned and actual rosters in place and the inspector found that these were well maintained and reflective of the staffing levels. There were regular reviews of the staffing position in the centre and these included decisions such as ensuring there was flexibility for residents if they wished to stay at home during the day or if they requested an alternative activity.

To cover planned and unplanned leave the provider now had access to a relief staff team that they used across their designated centres. This ensured greater

consistency of support for residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider and person in charge ensured that staff had access to training and refresher training as required. For the most part staff had completed mandatory and resident specific training. The inspector found however, that there were some gaps where not all staff had completed refresher training within the required time lines.

One member of relief staff for example required fire safety refresher training, one staff member required manual handling refresher training and one staff member required safeguarding refresher training. Another staff member was due safe medication refresher training. The provider had identified these gaps and had written communications with staff demonstrating that they were endeavouring to ensure that all training requirements were met.

The provider had requested that staff complete human rights training and on the day of inspection only four staff had not yet completed all of the sections. Staff spoke of how they used this training for instance when communicating more clearly with residents and had looked at a variety of ways to improve their support to residents when engaging with them.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure in the centre was clearly defined, and identified lines of authority and accountability among the team. There was a full time person in charge in post who had responsibility for this and two other centres operated by the provider. They were supported in their role by a full-time team leader and by a person participating in management for the centre.

The provider had systems for monitoring the quality and safety of care and support for residents and these were, for the most part being utilised effectively. The inspector found that while most areas requiring action had been identified by the provider some had not including the minor injury details as outlined under Regulation 31 where two systems of documentation did not work together. In addition while the review of residents finances had identified improvement in management of daily finances it had not identified the lack of detail in the recording of personal possessions.

The local management team were completing regular audits, were reviewing

incidents, trending and sharing learning with the staff team. The provider had completed an annual review and six-monthly unannounced visits in line with regulatory requirements. The had a system for tracking actions developed as part of their audits and reviews. The actions taken were bringing about improvements in relation to residents' care and support and their home. Some actions had not been completed within the timeframes as set by the provider, for instance the repair/replacement of a damaged kitchen counter was stated by the provider for completion at the previous inspection of the centre remained not completed.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The provider had clear policies and processes in relation to admissions into the designated centre. There had been a change to the residents living in this centre since the previous inspection. The inspector found that the provider had followed their processes and policy in the admission of residents who had come to live here.

Clear plans had been developed that gave weekly build-up targets for residents prior to moving that included visits to the house, selecting items for their new bedroom, meeting with peers and staff. Opportunities were in place for resident's family members or representatives to visit with them. Alongside these plans for residents the provider ensured that the staff team was knowledgeable in areas that may be important for the residents moving in and staff education and communication systems were in place.

All residents who had moved into the centre had contracts of care in place that had been discussed with them and they had signed these.

Judgment: Compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents occurring in the centre and the person in charge was aware of the requirement to notify specific incidents to the Chief Inspector of Social Services in line with the requirement of the regulations.

The inspector had completed a review of notifications received in advance of this inspection and found a number of three day notifications had been submitted after the required time frame. These all related to allegations or concerns of abuse. In addition minor injuries had not been notified as required. This had arisen as a result of the implementation of the provider's new recording system, whereby if an

incident did not note any injury but bruising subsequently developed these were recorded on a different system and not linked to the incident.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that residents were supported and encouraged to engage in activities of their choosing. Residents appeared comfortable and content in their home. Residents and staff engaged with the inspector over the course of the inspection and residents were observed to be out and about and to lead active lives.

As part of overall reviews of documentation the inspector reviewed residents' assessments and read a sample of residents' personal plans and found that they positively described residents needs, likes, dislikes and preferences. The personal plans described residents' communication and behaviour support needs. Positive communication practices were observed over the course of the day between residents and staff.

Regulation 12: Personal possessions

The provider had policies, procedures and systems in place to guide in the management of residents' personal possessions and finances. The provider's policy had last been reviewed in November 2022. The person in charge and team leader were completing quarterly reconciliations of resident finances and there were no stated concerns regarding these. However, not all residents had full access to their statements nor to their finances as outlined in the last report for this centre. This had been identified by the provider. The provider and person in charge had completed substantial work in supporting and advocating for residents and this work was ongoing.

In this centre the person in charge and team leader had completed a robust review of financial practice and of the safeguarding of residents monies since the start of 2024. This review and audit had found that historic practices had continued in this centre that were not in line with the provider's policy. These allowed for daily cash expenditure without receipts or oversight of spending. The person in charge found that over the first three months of 2024 for example, that €3,490 had been spent without receipts or review for four residents as part of a sample audit. Changes to practice were being introduced to align with the provider policy.

The person in charge had completed capability assessments with each resident to determine the level of support they may require. These were not found to be sufficiently detailed in guiding staff practice or in determining the level of support a

resident may require. For instance the assessment scoring direction stated "a score of less than 12-14 indicates an individual requires significant help". It was not clear on the levels of 'help' that a score of five may require in comparison to a score of 11 as example. This procedure requires review to sufficiently guide supports.

Further review of the recording of resident personal possessions was required. The inspector found that when an item of value was purchased by a resident that these had not been consistently recorded. It was not clear what items belonged to the residents and what were the provider's such as curtains or furniture that may have been selected by an individual.

Judgment: Not compliant

Regulation 17: Premises

This centre comprises a large bungalow set in it's own grounds on the outskirts of a town in Co. Wexford. Residents can access one of the provider's day services from the rear garden but these premises are separate to the centre. The residents all have their own bedrooms some of which are en-suite and there are two large communal bathrooms also available. There is a spacious living room and a large kitchen-dining room, with a smaller 'snug' living room available for all residents to use.

While some maintenance and repairs had been completed since the last inspection other areas that had been identified at that time as requiring repair or replacement had still not been completed. This included for example repair/replacement of a damaged kitchen counter. The provider had however, identified all works that were required and these were logged on their maintenance log. Works included re-tiling of one communal bathroom where some tiles were cracked and the replacement of the kitchen counter and kitchen cupboard doors were now scheduled for completion.

The inspector reviewed the provider's timelines for works identified as required and also the quotes that had been obtained. Plans were in place to ensure that decoration was completed in an ongoing manner. Residents had personalised their own private rooms and the home was comfortable and warm with one resident stating that they had asked if they could move bedroom and this was under review. The resident stated that being able to make this request had made them happy.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider and person in charge have previously completed works in the centre

relating to fire safety however, further review was found to be required in relation to containment measures during this inspection.

A significant number of the fire doors fitted in the centre had holes through them where works on keyholes had been carried out and some had exposed wood and cracks present. This did not provide an assurance that there would be adequate containment measures in place. In addition pipe-work had been fitted through the ceiling into the attic space from a press containing a hot water tank. The holes had not been sealed following this work. The person in charge stated that they would arrange a review of the fire doors by a suitably qualified fire safety expert.

The core staff team had completed fire safety related training and residents had personal emergency evacuation plans which were reviewed and updated regularly. Some further review of these plans was required where direction was given for the potential use of mobility equipment that was found to be located in other areas of the centre. This would result in staff having to move through containment doors in order to collect the equipment for resident use. Fire drills were occurring regularly and the records of these were detailed in nature and clearly identified the supports residents required to safely evacuate.

There were systems to ensure that fire equipment was serviced and maintained. Staff maintained records of when fire safety equipment was checked and tested.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had systems in place for the receipt, storage, administration and disposal of medications. The inspector found that there were good medication practices in this centre which ensured that this area of care was held to a good standard at all times. There was an allocated room established for medicine storage and this ensured staff could prepare for administration without interruption. Residents were welcome into the room and encouraged to observe as part of their education and development of their skills in this area.

There were current prescription records available. In addition there were records in place to indicate when medications were administered as prescribed. There were systems in place for the administration of as required medicines with details on which was a first choice for residents in addition to a warning system to ensure nothing was given within an incorrect timeframe.

The storage of medicinal products was clear and in line with the provider's policy with medicines returned to the pharmacy once they had expired. There were clear opening dates noted on labelling of any medicinal products so there was a means to record how long a product had been open.

All residents' had been assessed to review their ability to self administer or manage

their own medicines and the inspector was told by one resident that this was important to them. Residents had access to easy-to-read information and had access to their current medication list that outlined what they were taking and why.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to enjoy best possible health. They had their healthcare needs assessed and had access to a GP and a range of health and social care professionals in line with their assessed needs. An annual health overview was present for all residents that allowed for a review of supports and planning for future needs.

The inspector found clear protocols were in place to guide staff in supporting residents and there were where possible supports in place that encouraged residents to take the lead in managing their own health where possible. Specific health action plans were developed and reviewed as required. In addition to these management plans, flow charts were in place that provided information at a glance to guide in areas such as epilepsy or diabetes management.

Judgment: Compliant

Regulation 8: Protection

Notwithstanding the findings as outlined under Regulation 12 relating to the management of personal possessions the provider and person in charge had policies, procedures and practices in place to protect residents.

Allegations and suspicions of abuse were reported and followed up on in line with the provider's and national policy. Safeguarding plans were developed as required. Staff had for the most part completed training as stated under Regulation 16 and those who spoke with the inspector were aware of their roles and responsibilities should there be an allegation or suspicion of abuse. The person in charge and team leader had completed a review of all safeguarding plans that had been open in the centre and linked with appropriate external agencies to review and close these as indicated. The inspector reviewed the safeguarding register and the associated plans and found that 10 plans were developed in 2023 with four now closed. To date in 2024 two plans had been developed and both were now closed.

A sample of residents' intimate care plans were reviewed and found to be suitably detailed to guide staff practice to support residents in line with their wishes and preferences, while ensuing their privacy and dignity was maintained.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Beechhaven OSV-0002121

Inspection ID: MON-0039020

Date of inspection: 02/05/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></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:
The provider and person in charge ensured that staff had access to training and refresher training as required. The PIC has ensured where there were some gaps, where not all staff had completed refresher training within the required time lines have now been booked in for training and some staff have them completed.The PIC has requested that staff complete human rights training on HSE land by 31ST Of July 2024.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC in charge has systems for monitoring the quality and safety of care and support for residents and these were, for the most part being utilised. With regards Regulation 31 where two systems of documentation did not work together, the PIC and team leader have created a quarterly register to ensure all incidents of this nature are recorded and identified in a timely manner. The PIC and team leader have informed all staff in the event a body chart is completed that they log and complete an incident and give the incident to the teamleader and PIC within the time frame.
The PIC and teamleader had identified improvement prior to inspection in management of daily finances, The PIC and team leader have informed residents and staff to input more detail in the inventories with regards personal possesions ie curatains, furniture if purchased by the residents.
The PIC and Teamleader had sourced a number of quotes for the repair/replacement of a damaged kitchen counter since the last inspection. This has been escaulated to the provider who has given a date of 31st of August 2024.

Judgment: Substantially compliant</td></tr>
</table>

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC has created a new incident and notifiable register to highlight all notifables events to be submitted through the Hiqa portal within the time frame for three-day notification and quarterly returns. The PIC has completed a detailed list of what incidents are recognised for notification and has sent them to all team leaders and staff. Systems are now linked to the incident.

Judgment: Not compliant

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The PIC and teamleader have ensured that residents have full access to their statements,The PIC and team leader at the HSE residential reviews have informed residents and families that all statements are to come to the designated center where the residents live, residents to be supported to change addresses on the statements.
The person in charge had procedures in place for counting in and out of all monies in the designated center, this was doubled signed by staff, However in supporting residents in independent spending, the PIC and teamleader identified the shortfall in reciepts from community services to support independent purchases.The residents who wished to carry their own money were not requesting reciepts. Going forward it is encouraged for residents to use their bank card where possible and education around getting reciepts after every purchase. The PIC has ensured all monies have been checked every day, going forward money will be checked twice a day. Ongoing audits and spot checks carried out by the teamleader, PIC, service manager and accountant.
The person in charge is reviewing the capability assessments form and scoring sheet to best support staff in completing them to ensure we determine the level of support the residents may require.
The person in charge and the teamleader are reviewing the recording of resident personal possessions to ensure any items of value that was purchased by a resident that they are consistently recorded. The PIC and teamleader have informed staff that all items are to be logged properly and in detaill ie curtains, furniture that the resident has purchased.

Judgment: Not compliant

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The PIC and teamleader have identified some areas in the designated center that require repair or replacement, this was highlighted at the last Hiqa inspection. The PIC highlighted the repair/replacement of a damaged kitchen counter,works included re-tiling of one communal bathroom where some tiles are cracked and the replacement of the

kitchen counter and kitchen cupboard doors were now scheduled for completion by the 20th December 2024.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Person in charge contacted the local fire officer to come and inspect the designated center on the 24th of May, he advised to fill in the key hole's on the doors and he also stated some doors require imtunescsent fire strips to be repalced.The PIC is currently getting quotes and sourcing a company to replace the fire strips. Overall he was very happy with the center and its fire precautions and procedures. The fire officer is emailing over the report for our records. The fire officer was happy that the designated center had adequate containment measures in place. The PIC and team leader have requested the maintenance man where pipe-work had been fitted through the ceiling into the attic space from a press containing a hot water tank, that the holes be sealed. The teamleader and staff team have reviewed residents PEEPS where required and to give direction for the potential use of mobility equipment and to ensure the they were located in areas of the ceneter where staff would not need to move through containment doors in order to get the equipent they require. Judgment: Not compliant	

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/06/2024
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	14/06/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	20/12/2024

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	04/06/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	17/10/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	04/06/2024
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,	Not Compliant	Orange	27/05/2024

	suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	04/06/2024