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

Issued by the Chief Inspector

Name of designated centre:	Beauvale Residential
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	01 February 2022
Centre ID:	OSV-0002354
Fieldwork ID:	MON-0033123

About the designated centre

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

Beauvale is a designated centre operated by St Michael's House located in North County Dublin. It provides a community residential service to six adults with a disability. The designated centre is a large two-storey house which comprises of a main house and adjoining apartment. The main house consisted of a sitting room, quiet room, utility room, a kitchen/dining area, five individual bedrooms, a staff room, a toilet and a shared bathrooms. The adjoining apartment consisted of a living area, bathroom and an individual bedroom. The designated centre is located close to community amenities e.g. hospital, health centre, local shops, church, clubs and pubs. The centre is staffed by the person in charge, clinical nurse manager, staff nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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
Tuesday 1 February 2022	09:20hrs to 16:20hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

In line with public health guidance, the inspector wore a face mask and maintained physical distancing as much as possible during interactions with residents and staff.

From what the inspector was told by residents and staff, and from what the inspector observed, it was clear that residents were enjoying a good quality of life. The residents were supported in line with their assessed needs, and personal preferences and will. The residents were active participants in their communities and were involved in the running of their home.

The inspector had the opportunity to meet with several residents during the inspection. Some residents were busy getting ready to attend their day services and the inspector only spoke with them briefly. The inspector spoke with two residents in the accompany of a staff member, the residents indicated that they were happy living in the centre, felt safe, and had no complaints about the quality of care and support. Other residents did not verbally communicate with the inspector but appeared very comfortable and content in their home.

Some residents attended day services, and others were supported by staff to engage in activities within and outside of the centre. The inspector found that residents had active lives and engaged in activities meaningful to them such as gardening, cinema, bowling, swimming, walks on the beach, meals out, gym, shopping, visiting family, and attending mass.

The inspector observed staff members to engage with residents in a familiar and warm manner, and residents appeared very comfortable in their presence. Staff members spoken with described the quality of care and support of residents to be very good, and advised the inspector residents rights and choices were respected in the centre at all times. The inspector observed accessible information for residents on advocacy and complaints.

The needs and associated supports of the residents varied, and for some residents their needs had recently changed with the level of supports required increasing. The quality of care and support provided to residents was found to be good; however, some improvements were required to enhance the effectiveness of the care and support.

The premise comprised a large two-storey house with an adjoining apartment. The apartment was single occupancy and consisted of a bedroom, living area, and bathroom. The main house consisted of five bedrooms, bathrooms, kitchen, living areas, staff room, and utility room. There was a garden at the rear of the house. The centre was conveniently located to many community amenities and resources, and there was a vehicle available to transport residents. On the day of the inspection it was observed that the centre was found to be bright, homely, and warm. It was generally clean, nicely decorated and well maintained however some

areas required upkeep and attention, and the storage facilities were found to be inadequate. Each resident had their own bedroom, some were small however, they were found to be nicely decorated to the residents' tastes.

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

Capacity and capability

The registered provider had implemented governance and management systems to ensure that the service provided to residents was safe, consistent, and appropriate to their needs. However, some improvements were required to these systems and associated arrangements to ensure that they were effective.

There was a clearly defined management structure in the centre. The person in charge, based in the centre, was responsible for the day to day management. The person in charge commenced their post in November 2021, and was found to be suitably qualified, skilled and experienced. The person in charge had a very good understanding of the residents' needs. The person in charge demonstrated a commitment to quality improvement and since commencing in their role, had completed audits to identify areas for improvement. The person in charge reported to a service manager, who in turn reported to the director of services. The person in charge met with the service manager on a regular formal basis, and also maintained regular informal communication. The person in charge informed the inspector that these arrangements were adequate to allow for the escalation of any concerns or issues in the centre.

The registered provider had implemented effective systems to monitor and review the quality of care and support in the centre. The annual review for 2021 had been completed and included consultation with the residents. The feedback from the residents was positive and indicated that they were satisfied with the service. There were also six-monthly provider led audits which identified areas for improvement and corresponding actions for completion. Other audits had been completed such as a medication management audit. The person in charge completed a monthly data report on the governance and management of the centre. The report provided relevant information to the service manager and director of service to support their oversight of the centre.

To support the governance of the centre, the provider had prepared and implemented written policies and procedures. The policies and procedures were readily available for staff to refer to for guidance and direction. The inspector reviewed a sample of the policies and found them to have been reviewed as required.

The person in charge maintained a planned and actual staff rota. The staffing

complement and skill mix in the statement of purpose did not reflect the staffing arrangements on the rota. On the day of inspection, a new full time staff nurse commenced working in the centre. However, there remained a half time staff vacancy. To reduce the impact of the vacancy on the continuity of care of residents, the person in charge arranged for regular relief staff to cover vacant shifts. The person in charge informed the inspector that the staff skill mix required review and has requested a formal review of the rota with the service manager, to determine the most appropriate staff complement.

There were training programmes for staff to complete to support their delivery of care and support in line with best practice. The inspector and person in charge reviewed the staff training audit record, dated 31 January 2021, and found that a significant amount of staff required training in numerous areas. The deficits in the training presented a risk to the quality and safety of care delivered in the centre. Upon further review of the training records, the person in charge informed the inspector that the records may not have been an accurate representation of the actual training levels. However, no other more recent training audit was available.

The person in charge provided informal supervision and support to staff on a day to day basis. Formal supervision was also provided on a scheduled basis. Staff members spoken with, informed the inspector that they were very happy with the level of support and supervision, and felt that the person in charge was very responsive to their concerns. Staff team meetings occurred monthly. The inspector reviewed the minutes of the January 2022 meeting, and found them to be comprehensive and well maintained.

The inspector spoke with some staff members on duty. The staff members were very knowledgeable on the needs of the residents, and demonstrated a human rights based approach to care and support, speaking about residents in a very respectful and dignified manner.

There was a statement of purpose containing the information set out in Schedule 1. However, some of the information was incorrect and not reflective of the current arrangements in the centre.

The inspector reviewed a sample of the incidents which occurred in the centre, and found that they had been reported to the authority in line with the regulations.

Regulation 14: Persons in charge

The person in charge was in a full time post, and was found to be suitably skilled, qualified and experienced. The person in charge had a very clear understanding of the service to be provided, and demonstrated a strong commitment towards quality improvement and the delivery of a person-centred service.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual staff rota. Residents were supported by a team of nurses, direct support workers, and social care workers. On the day of inspection, there was a half time staff vacancy in the staff complement. The person in charge arranged for regular relief staff to cover vacant shifts, to promote continuity of care for residents.

The skill mix of the staff complement is going to be reviewed by the person in charge and service manager to determine what is most appropriate to the needs of the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff training audit record, dated 31 January 2021, reported on the training needs for staff working in the centre. The audit showed a large amount of staff to require training in numerous areas such as:

- One staff required training in the safeguarding of residents
- One staff required fire safety training
- Four staff required manual handling training
- Seven staff required Children First training
- Seven staff required training in Positive Behaviour Support
- Seven staff required training in the safe administration of medication
- Nine staff required COVID-19 training
- Eleven staff required training in the management of behaviours of concern
- Fourteen staff required training in diabetes management
- Fifteen staff required training in epilepsy management

In addition to the above training deficits, it was also found that nurses working in the centre required training in percutaneous endoscopic gastrostomy (PEG). The deficits in training posed a considerable risk to elements of the quality and safety of care provided to residents. The person in charge advised that the training audit may not be fully accurate but could not furnish an alternative audit.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure with identified lines of authority and responsibilities. The person in charge was supported in the governance of the centre by a service manager and director of service. There were arrangements for communication between the management team.

The registered provider had management systems in place to ensure that the service was safe, appropriate to residents' needs, and effectively monitored. Annual reviews and six-monthly provider led audits were undertaken and included consultation with residents. Areas for improvement were identified with corresponding actions for completion. There was also a suite of local audits undertaken to drive quality improvement. The person in charge completed a monthly data report for the service manager and director of service on areas such as, staffing, risks, training, quality enhancement plans, and incidents, to support their oversight of the centre.

There was effective arrangements for staff to raise concerns. The person in charge provided informal and formal support to staff. Staff members spoken with, advised the inspector that they were very happy with the level of support and supervision provided. In addition, staff team meetings occurred regularly. The inspector reviewed the minutes of the January 2022 meeting, and found them to be comprehensive and well maintained. The minutes discussed agenda items such as health and safety, infection prevention and control, fire safety, communication, staff training, personal protective equipment use, and residents' needs. The minutes also recorded who attended the meeting, and were subsequently signed by staff members to indicate that they read the minutes.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider has prepared a written statement of purpose containing the information set out in Schedule 1. The statement of purpose was available to residents and their representatives; however, some of the information was incorrect and required updating, such as the registration conditions and management details.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of incidents in the centre and found that the

person in charge had notified the chief inspector in line with the requirements of the regulation.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared and implemented written policies and procedures on the matters set out in Schedule 5. The policies and procedures were readily available to staff, and had signature sheets for staff to sign indicating that they read the policies.

The inspector reviewed a sample of the policies, such as the policies on admissions, provision of personal intimate care, residents' property and finances, staff training and development, and medication management, and found them to have been reviewed and updated within the previous three years, and more frequently as required.

Judgment: Compliant

Quality and safety

Residents' wellbeing and welfare was maintained by a good standard of evidence-based care and support, and there were systems and arrangements in place to ensure that the environment was safe. However, improvements were required in some areas including the premises, infection prevention and control, risk management, positive behaviour support, and personal plans.

The premise comprised a large two-storey house with adjoining apartment, and back garden. The centre was warm, homely, and bright. Residents had their own bedrooms, and access to adequate living space and bathrooms. It was generally clean and well maintained; however, some areas required attention and upkeep, and there was inadequate storage facilities. Staff members working in the centre had recently fund raised to decorate the centre; the decoration plans were still being determined.

Residents had full access around their home, and there was equipment to support their mobility needs. Equipment used by residents was well maintained and serviced as required. There was a vehicle available to transport residents however, it was found to require cleaning.

The provider had implemented systems and precautions to reduce the risk of infection to residents. There was hand washing facilities and appropriate waste

receptacles throughout the centre. There was also information displayed on personal protective equipment (PPE) and COVID-19. The provider had developed written policies on infection prevention and control, and staff also had access to public health guidance. The person in charge informed the inspector, that there was adequate stock of PPE, which the inspector observed stored in the shed. The inspector observed some staff members wearing PPE that did not adhere to public health guidance. The rationale was explained to the inspector however, the risk it posed had not been assessed and therefore, no appropriate measures had been identified.

The inspector observed personal products stored in open units in the bathrooms, this presented a risk of infection cross contamination. Some of the bathroom storage units had rust and thus, could not be cleaned properly.

To reduce the potential transmission of COVID-19, arrangements such as temperature checks were taken for staff and residents. The person in charge had also produced a COVID-19 plan to be followed in the event of a suspected or confirmed case, and had completed a self-assessment tool, risk assessments, and monthly infection checklists to ensure the appropriate measures were in place. The person in charge also spoke to the inspector about the learning that was applied followed an infection prevention control inspection in another of the provider's designated centres.

There were arrangements to ensure the centre was safe. The site specific safety statement outlined the safety arrangements for the centre, and the person in charge had completed general and individual risk assessments with identified control measures. A monthly health and safety checklist was completed to monitor the health and safety arrangements and to identify potential hazards in the centre. Emergency plans and missing person plans had been prepared however, they were overdue review.

There were effective arrangements to manage the risk of fire in the centre. There was a comprehensive fire evacuation plan and a fire safety risk assessment had been completed. A fire safety feedback report was also completed reviewing the fire safety arrangements. Individual personal evacuation plans were prepared for residents, and fire drills took place to test the evacuation plans. A new fire panel was installed in December 2021, and fire detection, fighting and containment equipment such as fire alarms, extinguishers, and emergency lights were in the centre. This equipment was serviced regularly and also checked by staff daily. To further test the fire arrangements, monthly and quarterly checks were completed. Some documentation maintained in the fire safety register folder required review, for example, the 'overview of unit fire safety responsibilities' was undated and referred to the previous person in charge, and the recording of daily fire checks required improvement.

Residents were generally observed to have a good quality of care and support. The inspector reviewed a sample of residents' assessments and personal plans, and found that the health, personal and social care needs of residents' had been adequately assessed, and personal plans were developed to outline the specific

supports required in order to deliver effective care. The level of support and intervention required by residents varied. For some residents, their changing needs required an increased level of support and intervention, and the long term suitability of the centre for some residents was been considered in line with their changing needs. Multidisciplinary team input and support such as dietitian, physiotherapy, speech and language therapy, and occupational therapy services were available as required. The person in charge was reviewing the residents' personal plans on a regular basis to ensure that they were up-to-date however, several plans were found to be overdue review.

The inspector found that residents' rights were respected and that they had choice and control in their lives. On the day of inspection, some residents attended day services, while others were supported by staff in the centre to partake in activities meaningful to them. Some day services had been suspended or curtailed due to the COVID-19 pandemic, and residents were keen to return again. Staff were advocating for them on this matter. In addition, staff members spoken with were able to demonstrate how residents' will and preferences were supported. Residents attended house meetings where topics such as, choices of activities and meals, and the upkeep of the house were discussed. There was also accessible information for residents on advocacy, complaints, and rights.

There were arrangements in place for the safeguarding of residents from abuse. There was a safeguarding policy that underpinned the arrangements, and staff were also required to complete safeguarding training. On the day of inspection, the inspector was informed that there were no active safeguarding concerns. The inspector reviewed an old safeguarding concern and found that the concern had been reported and screened, and that a safeguarding plan had been developed. Staff members spoken with were familiar with the procedures to be followed in the event of a safeguarding concern and could identify the designated officer. Safeguarding was discussed at residents meets to support their understanding of safeguarding matters.

A small number of restrictive procedures were implemented in the centre. The rationale for the restrictions was clear however, improvements were required in the oversight of the restrictions and to ensure that the provider's policy was adhered to, such as the appropriate recording, approval, and development of associated plans. The use of restrictions in the centre had been notified to the Chief Inspector on a quarterly basis.

Regulation 17: Premises

The designated was warm, bright, and generally well maintained. The residents' bedrooms were small, but personalised and nicely decorated. Equipment used by residents, such as stair lifts, nebulisers, and glucometers, were well maintained and there were procedures for cleaning them. Records were also maintained for the servicing of the stair lift and electric beds.

Generally, the house was clean, and there were arrangements for the cleaning and upkeep of the home. A review of the staff cleaning checklists found gaps in the daily checks for January 2021 however, the 'COVID-19 cleaning roster' was complete.

Some areas of the centre required upkeep:

- There was mildew around some bedroom and bathroom windows.
- The ceiling in the utility room was damaged and required painting.
- The ceiling in the kitchen was stained and required painting.
- The vents in bathrooms were dirty and required cleaning.

The storage facilities were inadequate. The shed was full with personal protective equipment and miscellaneous items, and not maintained in a tidy manner. The large upstairs press was full and could not accommodate any more items. Clothes were observed drying on radiators, and sheets were hung off doors. The person in charge was exploring alternative storage options such as shelving to improve the storage facilities.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had ensured that there was a comprehensive risk management policy. The person in charge had completed general and individual assessments on the risks that presented in the centre including the risk of falls, fire, COVID-19, self-injurious behaviour, and behaviours of concern. Control measures for risks were identified and implemented.

The registered provider had ensured that there were systems for responding to emergencies such as emergency response plans. However, the emergency response plans for the loss of heating and water, and gas leak were overdue review. In addition, the 'emergency plan for Beauvale' and 'the missing person guidelines', both dated 2019, required review.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had implemented measures and precautions to protect residents against the risk of infection however, there was areas that required improvement.

The registered provider had prepared comprehensive policies and procedures on infection prevention and control, and staff in the centre also had access to public

health guidance. The person in charge had completed COVID-19 risk assessments, and developed a COVID-19 plan to be followed in the event of a suspected or confirmed case. The plan included arrangements for access to personal protective equipment (PPE) and staffing arrangements. The person in charge also completed a COVID-19 self assessment tool and infection audits to assess the adequacy of the infection prevention measures.

There was adequate hand washing facilities, and supply PPE, as well as guidance on the correct use of PPE. However, not all staff were wearing appropriate PPE in line with public health guidance. The risk this posed had not been assessed and therefore, no appropriate measures had been identified.

The storage of personal products in open bathrooms units such as electric razors and residents' medical creams required reconsideration due to the risk of cross contamination of infection. In addition, some of the storage units in the bathrooms had rust and could therefor not be cleaned properly. There were arrangements for the cleaning of the vehicle used to transport residents however, it was found to require deep cleaning.

As noted under regulation 16, a number of staff required training in COVID-19.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had ensured that there was effective fire safety management systems in the centre. There was a comprehensive fire evacuation plan for the centre, and the person in charge had completed a fire safety risk assessment. A fire safety feedback report had taken place in 2021 to review the fire safety arrangements. Residents had individual personal evacuation plans to guide staff in supporting residents to evacuate the centre. Fire drills took place to test the fire evacuation plans, and included a night time fire drill when there was reduced staffing numbers.

A new fire panel was installed in the centre in December 2021, and there was fire detection, fighting and containment equipment such as fire alarms, extinguishers, and emergency lights. The equipment was serviced regularly. To further test the fire arrangements, daily, monthly and quarterly checks were also completed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that there was a comprehensive and up-to-date

assessment of residents' health, personal and social care needs.

The person in charge had ensured that corresponding plans were developed outlining the supports and interventions required to meet the residents' needs. However, the person in charge was reviewing the personal plans to ensure that they were up-to-date. The inspector reviewed a sample of the personal, and found several to require review such as plans on epilepsy, foot care, communication, and intimate care

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider had provided for appropriate health care for each resident. An assessment of residents' health care needs had taken place. Residents' health care needs were attended to by nurses in the centre, and residents also had access to a range of multidisciplinary team services as required, such as speech and language therapy, occupational therapy, physiotherapy, and dietitian services.

Judgment: Compliant

Regulation 7: Positive behavioural support

A small number of restrictive procedures were implemented in the centre. The rationale for the restrictions was clear; however, improvements were required in the oversight of the restrictions and to ensure that the provider's policy was adhered to. The date of use of restrictions was recorded but the times were not, therefore it was not evident that the restriction was used for the shortest duration required. In addition, it was the provider's policy that restrictions should be sent for approval to their oversight group. Approval was in place for most restrictions but had expired for some. The person in charge became aware of this on commencement of their role, and contacted the oversight group for approval, however, it has not been received by the day of inspection. The restriction plans observed in the centre did not fully align with the requirements of the policy, for example, there were no fading plans.

The use of restrictions was notified to the Chief Inspector on a quarterly basis.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had implemented measures and systems to protect residents from abuse. There was a policy on the safeguarding of residents that outlined the governance arrangements and procedures for responding to safeguarding concerns.

A review of a sample of safeguarding concerns found that they had been reported and managed appropriately, and where required, safeguarding plans had been developed and implemented.

There was accessible information on safeguarding available to residents and safeguarding was discussed at residents meetings, to support their understanding of safeguarding and protection.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had ensured that the centre was operated in a manner that respected and promoted the residents’ rights. Residents participated in the decisions about their care and support, and were supported to make choices and exercise control in their daily lives.

Residents were active participants in their community, and utilised local amenities such as the cinema, gym, restaurants, bowling alleys, swimming pools, beauticians, and shops. In the centre, they participated in activities such as gardening and knitting. Some residents were keen to return to their day services on a more regular basis following the easing of COVID-19 restrictions, and staff were advocating on their behalf for this.

Residents were consulted with about the running of the centre and attended residents meetings. There was also accessible information available to them on their rights, complaints, and advocacy

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Beauvale Residential OSV-0002354

Inspection ID: MON-0033123

Date of inspection: 01/02/2022

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
· · Ongoing recruitment of 0.7 Direct Support worker vacancy - Time frame; 30/5/2022
· Roster review scheduled for the 3/3/2022. It took place on 3rd March 2022.

Outcome: Required skill mix has been identified and looked at.</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
·
· · One staff Safeguarding : Completed 28/2/2022
· 2 staff require Fire safety training- One staff identified on the training audit and this staff completed course by 2/3/2022
· 4 staff Manual handling: all staff have completed Manual handing training by 2/3/2022
· 7 staff required Childrens 1st: all staff have completed 2/3/2022
· 7 staff PBS (positive behavior support) training- all staff have completed online refresher training and one staff scheduled to attend for initial programme April –July 2022. Will complete by end of July 2022
· 9 Staff required- Covid 19 - 6 monthly refresher: all staff have completed by 2/3/2022
· 11 staff required Training in Therapeutic Interventions practices re PBS- referral sent to Positive Approaches Management group for approval 9/3/2022
· 14 staff Diabetes management: Briefing with team scheduled for the 11/3/2022 and further date scheduled for those staff unable to attend by 30/4/2022
· 15 staff required PEG training- Only nursing staff support residents with Enteral feeding – CNM2{ person in charge} and 6 nurses A Multi-disciplinary Team in SMH (St. Michael's house) has been developing a programme with Dieticians' and CNSp Complex Health Needs. All face to face training in Enteral Tube Feeding stopped during the Pandemic as it is in the acute setting. During non Covid time's availability of places on</td></tr>
</table>

these courses are generally very limited. Awaiting dates for courses for 2022.
· 15 staff required Epilepsy training: all staff on site has completed SAM (Safe administration of medications) training and Epilepsy Training is an integrated Module in this training.
· Updated training audit completed with Training dept and all above information now reflective on template within the designated centre (DC)

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
· Reviewed Statement of purpose on the 1/2/2022 and updated

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
·· Review of all cleaning schedules for the DC by the PIC with daily planner identified and works delegated through this process. Done on February 2022.
· Review of storage within the DC and the acquisition of additional storage unit to accommodate PPE (personal protective equipment) supplies. New storage unit purchased and assembled on 6th March 2022.
· Staff made aware of the purpose of the fire doors and will no longer use them as a drying facility as of February 2022

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
·· Emergency response for Heating, Water, Gas have been reviewed and updated on 10/02/2022
· Emergency plan for Beuavale and Missing person guidelines has been updated on 10/02/2022

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
· Staff has been reviewed by Corporate Health Ireland (CHI) and recommendations regarding the type of masks have been put in place. CHI reviewed on 8th February 2022
· Replacement of damaged storage units with Closed wipeable bathroom cabinets. Completed by 15th March 2022.
· Cleaning schedule in place for the unit bus, all drivers are aware of their requirement to ensure the schedule is followed. Cleaning Audit of vehicle is now included as part of a weekly schedule
· All staff have completed their Covid 19 refresher training

Regulation 5: Individual assessment	Substantially Compliant

and personal plan	
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: ·· All residents assessment of needs (AON) are updated by February 2022 and corresponding support documentation will be reviewed by end of March and guide practice	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: ·· All staff have signed as read and understood SMH Restrictive practice policy · All Restrictive practices have been referred to Positive Approach management Group in a timely manner to ensure the approval is in place February 2022 to guide staff · Implementation of recording sheet requirements for the use of restrictive practice's to establish frequency and requirement for reduction in restriction by February 2022 · Review of Restrictive practice log with addition of section to identify all attempts at removing and reducing restriction	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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.	Substantially Compliant	Yellow	30/04/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/05/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Not Compliant	Orange	30/04/2022

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/04/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2022
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	28/02/2022
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 healthcare	Substantially Compliant	Yellow	28/02/2022

	associated infections published by the Authority.			
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	02/03/2022
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	28/02/2022
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	28/02/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Substantially Compliant	Yellow	30/07/2022

	to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/03/2022
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	30/03/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/03/2022