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:	Pinegrove
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Announced
Date of inspection:	12 October 2023
Centre ID:	OSV-0002605
Fieldwork ID:	MON-0032594

About the designated centre

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

Pinegrove is a centre run by the Health Service Executive and is located on a campus setting a few kilometres from a town in Co. Sligo. The centre provides residential care for up to 8 male and female residents, who are over the age of 18 years and have a moderate to profound intellectual disability. Each resident has their own bedroom. There are shared bathrooms and communal areas and access to a garden area. Staff are on duty both day and night to support the residents who live there.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 12 October 2023	09:25hrs to 18:00hrs	Sarah Cronin	Lead
Thursday 12 October 2023	09:25hrs to 18:00hrs	Nan Savage	Support

What residents told us and what inspectors observed

This announced inspection took place to inform a decision about an application to renew the registration of this centre. Inspectors found that while residents were well cared for in areas such as healthcare and positive behaviour support, the layout and design of the premises negatively impacted upon residents' quality of life, on the provision of individualised supports and on residents' rights. Inspectors found a deterioration in the levels of compliance with the regulations since the last inspection, with improvements required in residents' rights, general welfare and development, personal possessions and premises. These are outlined in the body of the report.

The centre is home to eight adults with intellectual disabilities. It is located on the first and second floor of a large three-storey building on a campus in a rural area of Co. Sligo. Up to recently, the building housed a second designated centre which was now closed. The third floor was occupied by administrative and clinical staff. There were two different units in the centre, with one being home to six residents and the other unit being home to two residents. Downstairs, the centre was accessed through a communal entrance and a corridor which was shared with staff working in the building and on the campus. One of the dining rooms was off of this corridor and accessed via the staff canteen. The remainder of the ground floor accommodation comprised of another dining room area which had a small relaxation room off it. There were two sitting rooms, an office, staff toilets and residents' toilets.

Upstairs accommodation was on the middle floor of the building and accessed via a lift or a stairwell. Most residents required assistance to use the lift due to their mobility requirements. Residents had their own bedroom and these were located on two long corridors which had a number of other rooms now vacant. Three residents lived on one corridor and had access to a shower and toilet room. The other five residents had their bedrooms on another corridor and they had access to three bathrooms. Residents' bedrooms were clean and tidy and each bedroom had different wallpaper on one of the walls in the room. Some photographs were on the walls and one resident had some furniture and decorations in their bedroom. However, for the most part they were found to be sparse and contained a bed, a wardrobe and some residents had lockers and chest of drawers. Curtains and curtain rails remained on the ceiling in some bedrooms from when these rooms had been shared. One of the bathrooms had a lockable door. Within this bathroom was a large shower which did not have any door or curtain. This had the potential to impact on residents' privacy and dignity while they were showering. While residents were free to access all of the centre at any time, residents were required to access upstairs via a lift or stairs. Many residents required staff assistance to use a lift. Staff reported that residents did not tend to go upstairs during the day. During times which inspectors were on the ground floor of the building, they observed that residents moved in small groups to different rooms such as the sitting room, the

bathroom and the dining room in the company of staff.

The provider had a de-congregation plan in place to move out the residents living in the centre into homes in the community and to other houses on the campus in 2024. Two houses were purchased and in the process of being refurbished and equipped to best meet residents' needs and to ensure that they could be supported to age in these new homes. Residents had transition plans in place with input from a number of health and social care professionals. Compatibility of different resident groups was being considered and assessed.

Residents in the centre had complex communication support needs and used a number of different methods to communicate such as facial expressions, gestures, some words and bringing staff to the items they wanted. This required staff to have a good knowledge of each resident in order to be able to interpret their communication attempts and respond appropriately. In one of the dining rooms, inspectors saw two visual schedules on the wall which were used to support residents' understanding of their routine each day.

Inspectors had the opportunity to briefly meet with five of the residents living in the centre on the day of the inspection in line with their assessed needs and expressed preferences. All of the residents were well presented and appeared well cared for. They seemed comfortable in their surroundings and in the company of staff. Inspectors discretely observed residents having at lunchtime and found staff assisted residents who required support in a respectful and dignified way. On arrival, three of the residents were going into the main sitting room area with a member of staff. One resident smiled in response to interactions. Shortly afterwards, two residents returned from a walk and greeted the person in charge with a smile. It was evident that the person in charge and the residents knew each other well.

Residents had access to sessions in a day service which was located on the campus. Activities they did in the service included exercise, flower arranging, dog therapy, arts and crafts and reflexology. One of the residents enjoyed walking and did so most mornings with their support staff. The provider's six-monthly unannounced provider visit indicated that all residents had a 'community experience' once a week. These community experiences included seaweed baths, horse riding and swimming. However, a review of residents' finances and activities indicated that residents were not accessing many other local amenities or activities.

Residents in the centre ate their meals over staggered mealtimes in two different dining rooms. One of these dining rooms was in the main part of the centre while the other was through a communal corridor and through the staff canteen. Meals came from a central kitchen and from an external company. Hot boxes were in operation to keep meals warm and there was a small amount of snacks available in each dining room. Residents did not buy or prepare food and had access to small kitchenettes which had portable hobs. Staff reported that residents could bake using these hobs if they wished to do so. It was evident that where a resident did not like the meal provided, that they could access another option in the staff canteen. However, times were generally set for main meals in the centre, with choices of

meals dictated within the menu available on campus.

Residents' finances were held in an account within the organisation in accordance with the provider's policy. However, residents could access money during office hours on week days only. Some finances were held in a central account, with a proportion of the residents' finances held locally. The person in charge did not have any documentation or statements on how much money residents had. Medications were managed by a pharmacy based in a local hospital. It was planned that residents would begin to access a local pharmacy when the centre closed.

Residents' meetings took place on a monthly basis and there was a standing agenda in place which included safeguarding, complaints, fire, privacy and dignity and recreation and leisure. Minutes indicated that staff were discussing residents' upcoming move and they noted activities that residents had taken part in. It was unclear how consultation and choice making was facilitated in these meetings, or what residents' responses or reactions to information shared was in line with residents' communication needs.

In summary, from what residents told us and what inspectors observed, residents were well cared for and appeared to be comfortable in their home. Staff were noted to be kind in their interactions with residents. However, the design and layout of the premises meant that providing person-centred and individualised supports was a significant challenge. Residents were required to access some parts of their home through shared corridors used by staff who did not work in the centre. It was not possible for staff to support residents to fully participate in the running of their home, or to develop independent living skills such as preparing meals, shopping and doing laundry. The nature of the service setting meant that there were institutional practices in relation to mealtimes, finances and day-to-day routines. This negatively impacted upon residents' rights and quality of life. The next two sections of the report will present the findings in relation to the governance and management of the centre and how these arrangements affected the quality and safety of the service being delivered.

Capacity and capability

Inspectors found that there were management structures and systems in place to monitor and oversee the quality and safety of care of residents in the service. Improvements were required in the areas of staffing and governance an management. The provider had a clearly defined management structure in place which identified the lines of authority and accountability. There were arrangements in place to manage absences of the person in charge where required in addition to on-call arrangements. The provider had carried out an annual review and six-monthly unannounced provider visits in line with regulatory requirements. However, the annual review did not outline consultation with residents and the outcome of that consultation.

The provider had an audit schedule in place which outlined time lines for audits pertaining to different service areas. For example , finances, medication and incidents were audited on a monthly basis, while fire safety and complaints were audited on a quarterly basis. Inspectors found that these audits were completed in line with the provider's schedule. The person in charge monitored and implemented actions as part of the centre's quality improvement plan. This action tracker was made up of findings from audits, six-monthly unannounced provider visits and previous HIQA inspections which was regularly reviewed.

The person in charge attended regular management meetings and it was evident that these meetings were used as a forum to share learning and information across service areas. Staff meetings took place on a monthly basis. A review of the minutes from these meetings indicated that there was a set agenda in place which included discussion of previous minutes, sharing learning from HIQA inspections, infection prevention and control and a number of other areas.

On the day of inspection, the staffing levels were of an appropriate number and skill mix to meet the assessed needs of residents. The person in charge had ensured that planned and actual staff rosters were maintained. Inspectors found that the person in charge had adjusted staffing arrangements to reflect the changing needs of residents including increasing staff support for one of the residents when required. There was also a 24 hour on-call nursing service available to staff outside of working hours that provided support in the event of emergencies. Three agency staff were listed on the staff roster and the person in charge showed inspectors that they would be rostered alongside experienced staff. A sample of staff files were reviewed by inspectors and it was noted that some required information was not available. For example, Garda vetting was not available for one staff member while there were gaps in the employment history of a different staff member. Confirmation of Garda vetting and safeguarding for agency staff was not available in the centre. However, the person in charge confirmed that this was in place for all staff who completed shifts following inspection, in line with the provider's service level agreement with agencies.

The person in charge maintained a staff training matrix which enabled them to have good oversight on staff training and time lines for refresher training. This indicated that staff had received training in mandatory areas such as fire safety, safeguarding, manual handling and cardiopulmonary resuscitation. They had completed additional training in areas related to infection prevention and control and human rights. A number of staff were due refresher training in managing behaviours of concern and this was scheduled. Staff supervision took place annually in line with the provider's policy on staff training and supervision.

The provider had ensured that policies and procedures required under Schedule 5 of the regulations were maintained to guide practice on matters including visitors, provision of intimate care and health and safety, including food safety, of residents, staff and visitors. There was evidence that policies and procedures were kept under review and made available to staff. While there was a policy in place for CCTV (closed-circuit television), this policy was not specific to the service. For example, the number and location of the CCTV in use had not been identified. Inspectors

noted that CCTV was in operation on the grounds and not inside the centre. Inspectors were informed that the CCTV was used for security reasons and a risk assessment was provided following the inspection.

Regulation 15: Staffing

Schedule 2 documents indicated some gaps in relation to employment history and Garda Vetting for a number of staff employed in the designated centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had completed mandatory training in a number of areas including fire safety, safeguarding, manual handling and a range of modules pertaining to infection prevention and control. A number of staff were due to have refresher training in managing behaviours of concern. This was booked for the weeks following inspection. Staff had also completed modules in CPR, supporting residents with feeding, eating, drinking and swallowing difficulties and on human rights. Supervision took place once a year in line with the provider's policy.

Judgment: Compliant

Regulation 23: Governance and management

The provider's annual review of the quality and safety of care had taken place. However, there was no written evidence of consultation with residents to ascertain their views on the service.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had prepared and implemented policies and procedures required by Schedule 5 of the regulations. The policies were reviewed within required time frames.

Judgment: Compliant

Quality and safety

Residents well being and welfare was maintained by good care and support. However, a number of areas required improvement in the areas of rights, personal possessions, general welfare and development and the premises.

Residents were found to be in receipt of good health care. They had access to a general practitioner and a range of health and social care professionals including occupational therapy , speech and language therapy, dietetics and nursing care. Residents had hospital passports in place and had access to nursing at all times.

The provider and person in charge had ensured that positive behavioural support was well provided for in the centre.Inspectors viewed a sample of risk assessments and positive behaviour support plans that. Inspectors found that these were detailed and clearly outlined proactive and reactive strategies in place. Inspectors noted that residents' behaviours were closely monitored and reviewed. Psychiatric reviews were taking place as well as regular input from the Clinical Nurse Specialist in behavioural support. Some restrictions were in place for safety reasons and these were regularly reviewed. There were risk assessments undertaken, multidisciplinary input into decisions taken including referrals made to the organisational human rights committee.

As outlined at the beginning of the report, routines, practices and facilities in this centre did not promote residents' autonomy, independence or their choice. For example, residents' routines appeared to be largely dictated by the centre such as mealtimes and times to engage in activities. Meals and laundry were centrally managed on the campus. This meant that residents' rights to independence and to learning those life skills was compromised due to the nature of the centre.

Residents did not appear to have many personal possessions in their bedrooms. Spaces were clean and tidy, but appeared sparse in nature and not reflective of individual interests and histories. Residents did not have timely access to their finances in the centre, with some of their finances held in a central account off the campus. Statements were not available in the centre and while this was within the provider's policy, inspectors were not assured that finances were appropriately monitored, and that residents' access and control of their personal possessions was adequate.

As outlined at the beginning of the report, residents accessed sessions in a day service on the campus. These included activities such as dog therapy, exercise, gardening and arts and crafts. However, inspectors were not assured that individual residents were provided with opportunities to regularly engage in activities in their local community, or to access local amenities.

The premises of the centre did not enable the staff and management to achieve the aims and objectives of the service set out in the statement of purpose. Despite the provider's efforts to personalise spaces and make them homely, bedrooms were sparsely decorated and equipped. There were long corridors, with many vacant rooms which meant that it was not a homely atmosphere and was institutional in nature. This is further discussed under Regulation 17: premises below.

The provider had a risk management policy in place which met regulatory requirements. All incidents were reviewed at senior management level and escalated to the Quality and Safety Committee. There were systems in place to ensure risks were identified, assessed and managed within the centre, for both residents and staff. A review of incidents indicated that while there was a relatively low level of incidents in the centre, these were appropriately documented and trended.

Regulation 12: Personal possessions

Residents access and control of their personal property and possessions was compromised in the centre. Inspectors found bedrooms to be sparse in nature, both in terms of the furnishings and the personal affects in them. The individual interests and preferences of residents were not evident or reflected in their bedrooms.

Residents' finances were managed in line with the provider's policy on the management of residents' finances, which meant that residents' finances were paid into a central account and then some of their finances were transferred to a local patient private property account which was held by the finance office on-site. Finances had to be requested in advance and were reported to be available in office hours during the week. A review of residents' finances in the centre indicated that at local level, receipts were kept and monies spent were logged. However, the person in charge did not have any statements or indication as to how much money residents had in their account. Inspectors were not assured that finances were appropriately safeguarded, and that residents' access and control of their personal possessions was adequate.

Judgment: Not compliant

Regulation 13: General welfare and development

Inspectors found that while the provider provided some opportunities for residents to engage in day services on site, residents were not provided with ample opportunities to engage in community settings or to use and enjoy local amenities. For example, a review of activity logs and financial records indicated that residents were mostly going for drives and walks around the grounds. These records indicated that residents were spending small sums of money each month, between two and

ten euro. Some months, residents did not spend any money. This indicated that community engagement and accessing activities outside of the centre were limited.

Judgment: Not compliant

Regulation 17: Premises

As outlined at the beginning of the report, this premises did not meet the centres' aims and objectives and due to the poor layout and design, the building did not support or promote residents' rights to independence, to freedom of movement within their home and the right to have control over daily routines. There were spaces shared with administrative and ancillary staff and residents' did not freely access their bedrooms to spend time alone during the day.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place which met regulatory requirements. There were systems in place in the centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Judgment: Compliant

Regulation 6: Health care

Residents in the centre were supported to have best possible health. They had access to a general practitioner, an advanced nurse practitioner and other health and social care professionals such as occupational therapy, speech and language therapy, a clinical nurse specialist in behaviour and a physiotherapist. Residents also access psychiatry services in the community.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' who required positive behaviour support plans had them in place and had

access to a behaviour specialist where it was required. Plans were detailed and contained proactive and reactive strategies for staff to use.

Judgment: Compliant

Regulation 9: Residents' rights

As outlined earlier in the report, residents' rights were negatively affected in the centre due to the layout and design of the physical premises, and due to the service provided within the centre. For example, residents' right to autonomy and independence relating to their finances, their ability to prepare meals, their ability to launder their own clothes were impacted upon. Residents' right to engage in activities within their communities was limited. Routines in the centre also impacted on residents' ability to have choice an control over their daily lives.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Pinegrove OSV-0002605

Inspection ID: MON-0032594

Date of inspection: 12/10/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to achieve compliance with Regulation 15: Staffing, the following actions will be undertaken; • The Person in Charge has provided the date of completed Garda Vetting for the identified staff member to the Authority on 16/10/23. • Garda vetting renewal will be completed for fifteen staff working within his center. The Garda Vetting invitation has been distributed to all fifteen staff on the 08/11/23. Date to be completed by 30/12/23. • A full employment history has been requested from the staff member and gaps in the employment history will be completed as per schedule 2 requirements. Date to be completed by 13/11/23. • An Audit of Staff Personal files will be carried out annually as per CHO1 Audit Schedule. Date to be completed by 13/11/23.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to achieve compliance with Regulation 23: Governance and management, the following actions will be undertaken; • All residents and their representatives have been communicated with retrospectively and the registered provider's annual review has been updated to reflect the outcome of this consultation. • The revised interactive HIQA survey is currently being completed with each resident and feedback from the surveys has been included in the revised registered provider's annual review report. Completed by 13-11-23 • For all future annual reviews, the provider will ensure there is consultation with residents and their representatives.	

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
In order to achieve compliance with Regulation 12: Personal Possessions, the following actions will be undertaken;

• Each resident's bedroom has been re-evaluated and personalized with personal effects considering the residents interests, will and preferences, assessments of need and personal safety.

• Each resident's bedrooms have been refurbished with new bed linen in line with their personal preference.

• Having considered identified risks and individual behavioral support requirements for each resident additional safe furnishings have been put in place within individual bedrooms.
• Individual risk assessments and positive behavior support plans have been reviewed by the CNS in Behavioral Therapy and updated to reflect the risk of injury of harm from self-injurious behavior and falls in relation to furnishings in individual bedrooms. Completed on 10-11-23

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
In order to achieve compliance with Regulation 13 the following actions will be undertaken ;

• Each residents person centered plan is currently being reviewed taking into consideration the will and preference of each resident. Individual plans have an increased focused on community engagement and participation. New personal goals are being considered and agreed in conjunction with the residents by their key workers.
• Historically a number of activities untaken by residents have been paid from the HSE's central accounts office within Cloonamahon. Going forward, each resident will pay for their personal activities through their own personal account, which will be held within the center.
• The National Patient Private Property Team have been contacted and each resident's personal financial statements will be retained on file within the center. Statements will be stored in a secure manner to ensure confidentiality. Each residents will have access to view their statements in accordance with their will and preference.

• Each resident's financial competency assessment is currently being reviewed and updated to reflect their capacity in relation to managing their personal finances.

• Activity response sheets have been implemented within the center and will be audited by the person in charge on a monthly basis to monitor ongoing community engagement

for each resident.

Date to be completed by: 30-11-23

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to achieve compliance with Regulation 17 the following actions will be undertake;

• The center is situated on a congregated setting and is set to de congregate by 30/4/24.

• Two premises have been purchased and are currently under renovation to accommodate residents currently residing within this designated center. Upon completion of the renovations, an application for registration will be submitted to the authority for the two premises. The registration paperwork is being prepared currently and will be submitted to the authority once the building works have been completed.

• Individual transition plans are been prepared for each individual in line with their personal preferences.

• All residents now have access to choice boards which includes photographs of their bedrooms and all living areas .This will ensure choice and accessibility is available to residents according to their will and preference .Residents will be supported throughout each day to use these choice boards to assist them in their communication – There is sufficient staff on duty within the center to support this. This action is completed 13-11-23

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
In order to achieve compliance with Regulation 9 the following actions will be undertake

• Questionnaires are currently being completed with each resident to seek feedback in terms of their experience within the current center with their representative and key workers
• The Speech and Language Therapist has been contacted to support the service to consider alternative methods of communication for residents who require support in the area of communication to ensure their views are captured.
• Residents have access to laundry facilities within the designated center and can launder their own clothes depending on their will and preference with the assistance of staff.
• Residents are afforded the opportunity assisted by staff if required to prepare light meals and snacks outside of mealtimes within the designated center. Resident's preferences are recorded as part of their person-centered plan.
• Residents have access to cooking facilities adjacent to their living area.
• Residents have access to picture board's communication systems and one resident has access to choice boards.
• Each residents person centered plan is currently being reviewed taking into

consideration the will and preference of each resident. Individual plans have an increased focused on community engagement and participation. New personal goals are being considered and agreed in conjunction with the residents by their key workers.
• The National Patient Private Property Team have been contacted and each resident's personal financial statements will be retained on file within the center. Statements will be stored in a secure manner to ensure confidentiality. Each residents will have access to view their statements in accordance with their will and preference.
• Each resident's financial competency assessment is currently being reviewed and updated to reflect their capacity in relation to managing their personal finances.
• Privacy notices are located at each entrance of the designated center to indicate that this is a resident's home and not for free access to any staff other than those required to be in the center.

To be completed 30/11/23

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	10/11/2023
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/11/2023
Regulation 15(5)	The person in charge shall ensure that he or she has obtained	Substantially Compliant	Yellow	30/12/2023

	in respect of all staff the information and documents specified in Schedule 2.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/04/2023
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	30/04/2024
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	Substantially Compliant	Yellow	13/11/2023

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/11/2023
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, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/11/2023