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:	Avalon House
Name of provider:	Health Service Executive
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	11 October 2023
Centre ID:	OSV-0003694
Fieldwork ID:	MON-0040839

About the designated centre

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

This designated centre provides full-time residential care for seven adults with an intellectual disability, both male and female and over the age of eighteen. The centre is a large detached bungalow a few kilometres outside the nearest town. The centre comprises fifteen rooms including two small storage rooms and a lobby area. There is a kitchen, dining room, sitting room, utility room and seven bedrooms, all with en-suite facilities. There is one separate bathroom and one wheelchair accessible toilet. The centre has a large garden and patio area at the back of the house. It has its own transport; a wheelchair accessible vehicle and a people carrier. The person in charge works full-time in this centre and the staff team includes both nurses and health care assistants. Staff provide support to residents during the day and at night.

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
Wednesday 11 October 2023	18:30hrs to 22:00hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This inspection was conducted out of hours to monitor on-going compliance with regulations and standards, and in particular to monitor the assurances submitted by the provider on the agreed actions from the inspection of June 2023.

The focus of the inspection was to assess the improvements made based on these assurances, and was limited to these areas, with the exception of regulation 28 relating to effective fire safety management systems, which was also inspected against based on the observations of the inspector on the evening of the inspection. The findings relating to this area are discussed under regulation 28 of this report.

An initial 'walk around' of the centre conducted by the inspector immediately indicated improvements based on the agreed actions following the previous inspection. The designated centre was clean and uncluttered, and residents were occupied and appeared to be comfortable. The inspector found that residents were enjoying relaxation time after their evening meal, and most residents were in the company of either other residents or members of staff.

Some residents were happy to have a chat with the inspector, about their daily lives and about their home. One of the residents was proud to indicate the newly painted walls in their living room, and declared 'isn't it beautiful' and went on to point out the new blinds, and to describe how efforts to put a blind on one of the doors had been unsuccessful, and told the inspector how this had gone.

Both the inside and outside of the centre had been painted, and all residents had been involved in choosing the colours of paints in their rooms, and all the rooms that the inspector was invited into were nicely decorated and contained various personal items in accordance with the choice of each resident.

Some residents had been on an outing on the day of the inspection, and had arrived only shortly before the commencement of the inspection. It was evident that there were multiple outings available to residents, and that significant efforts had been made to ensure outings and activities that were meaningful to residents, and which they enjoyed. Some further improvements were required to ensure clear oversight of activities, and to ensure that there were no lengthy periods of inactivity for every resident, but the changes made since the previous inspection had resulted in improved outcomes for residents.

The inspector acknowledges that the person in charge had gone off duty at the time the inspection started, but returned to the centre to facilitate the inspection. In addition, all staff members engaged by the inspector discussed their enthusiasm for supporting residents to the best of their ability, and it was clear that there was a competent and caring staff team who were keen to address the issues that had been raised during the regulatory processes.

Overall the inspector found significant improvements across all the regulations previously inspected against, and in particular in relation to the rights of residents to have a meaningful life. However, further improvements were required to ensure compliance with the regulations. In addition observations made by the inspector raised additional concerns about fire safety in the centre which are outlined under regulation 28 in this report.

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

Capacity and capability

There was a clearly defined management structure, and the provider had made arrangements to ensure that key management and leadership roles were appropriately filled.

Required improvements identified in the previous inspection had all been completed, or were within the agreed timeframes. The provider had been required to submit a monthly update on progress towards compliance with the regulations, and these updates had all been submitted on time. The inspector reviewed all the actions outlined in these updates, and found that all had been completed or were within the agreed timeframes, although further improvements were found to be required during this inspection.

Significant improvements had been made in documentation, both in relation to care planning and in recording. Incidents were now recorded appropriately and learning from any incidents was readily available. Improvements had been made in the opportunities being made available to residents, and to the variety of activities they were engaging in.

The staffing numbers had increased and there was an additional staff member on duty until 10pm each day, although the role and function of this additional staff required development.

Overall, oversight of the care and support offered in order to ensure a meaningful life for residents, and to monitor the daily care and support being offered to residents was significantly improved.

Regulation 23: Governance and management

Significant improvements had been made across all areas since the inspection of June 2023. Following that inspection the provider submitted a compliance plan, and

in addition was required to submit to HIQA a monthly update on the progress towards compliance in the areas identified by HIQA as requiring significant improvement.

All of the actions identified by the provider as being required to bring the centre into compliance had either been completed, or were within their required timeframes. Whilst some improvement were still required, as further outlined in this report, this was not due to the lack of action taken by the management and staff team. Significant actions had been taken, and there was a measurable improvement in the outcomes for residents.

Improvements in the premises were either completed or were underway. The provider had undertaken to make changes to the premises in the form of the addition of an adjacent self-contained apartment to support the needs of one of the residents to remain in their home whilst also minimising the risks to other residents from their behaviours of concern. The building of this extension to the main building was underway, and was within the agreed timeframe for completion of the construction.

Deep cleaning of the centre and painting throughout, both internally and externally had been completed. The addition of external storage was also within the timeframe agreed with the provider, and was underway.

Improvements had been made in relation to documentation, and the recording of accidents and incidents was appropriate. However the system of recording of activities for residents was not yet adequate so as to ensure available data on which to base oversight of this area of care and support.

There were audits of care plans in place which had been conducted by the person in charge and the person participating in management in conjunction with the keyworkers, and a review of these indicated that they were thorough and detailed. A monthly oversight template was in place, and the completed templates for the two months prior to the inspection were reviewed by the inspector and found to be an effective overview.

The inspector observed the shift handover on the evening of the inspection, and again found this to be an appropriate system of disseminating up-to-date information on each resident, and of ensuring that any required tasks were highlighted.

The minutes of recent staff meetings were reviewed by the inspector, and there was a clear record of the discussions which took place at these meetings. Various required actions were identified at these meetings, and examples of these actions reviewed by the inspector had been completed, for example, where had been identified that staff should undertake training in relation to advocacy, this action had been completed. Other agreed actions were within the identified timeframes, for example the requirement for staff training on dementia care had a reasonable completion date which had not yet been reached, and the inspector saw that this training was planned. This was also the case for the review of goals set for

residents, and this action was also within the agreed timeframe.

Since the previous inspection an additional staff shift had been put in place, with the purpose of ensuring activation for residents, especially during the evening. However, while this action had been implemented, improvements were still required to ensure that these additional hours were meaningful, and that they would result in improved outcomes for residents. There was no evidence of structured tasks for this additional staff member, and the inspector found that the hours could be more usefully employed to the benefit of residents. For example, on the evening of the inspection this additional staff member was observed to be supporting a resident with their supper, and this basic need had already been met prior to the additional hours.

Accident and incidents reporting and recording was effective. There had been only one incident since the previous inspection, and the record included appropriate information and learning outcomes from the incident. There was also a detailed record of minor incidents in the daily notes in sufficient detail so as to ensure sharing of information between the staff team.

Completion dates for the structure of a self-contained apartment which had been agreed as a requirement for one of the residents to ensure that other residents were safeguarded from possible behaviours of concern were on time, in accordance with the actions agreed with the provider. However, the completion and sign off of a 'cabin' type construction which had been agreed as being required to offer an alternative space to provide an area for sensory activation had not been progressed.

Judgment: Substantially compliant

Quality and safety

There were various systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. Each resident had a personal plan in place, and all had been recently updated, although additional detail was required in some areas to ensure sufficient information as to guide staff in the delivery of care and support to residents.

Significant improvements had been made to ensure meaningful activities for residents, and to support and uphold their rights. Some further improvements were required to ensure consistent consultation with residents, and the person in charge undertook to ensure that the good practice found in relation to one of the recent residents' meetings would be continued.

Healthcare was effectively monitored and managed for residents, and there was evidence of a timely response to healthcare needs. The aspects of medication management reviewed on this inspection were found to be in accordance with best practice.

All staff engaged by the inspector were knowledgeable about the care and support needs of residents, and discussions with staff indicated that they were enthusiastic and committed to ensuring a good quality of life for each resident.

Overall it was the finding of this inspection that the person in charge and the management team were making significant progress towards ensuring compliance with the regulations, and that there was a competent and caring staff team who were keen to be involved in making improvements. This had resulted in improved outcomes for residents, and the inspector found that not only had significant progress been made, but that there was a commitment to quality improvement in the centre.

Regulation 13: General welfare and development

There had been multiple improvements in the support for residents to ensure a meaningful day and meaningful occupation and activation since the previous inspection, and there was evidence of a wide variety of activities being facilitated for residents.

Various activities and outings had taken place. Some residents had been on an outing on the day of the inspection to a local attraction. On other days residents had been involved in parties and visits. Outings had been organise to shows that residents were interested in.

Music therapy had been identified as being meaningful for some residents. A music therapist had been sourced, and while awaiting the availability of this therapist, one of the staff members who was a musician had undertaken to provide music sessions in the residents' home. A video of one of these sessions was shown to the inspector, and it was clear that residents enjoyed the activity, that staff were ensuring their engagement and that it was a lovely experience for them all.

One of the residents had been facilitated to have a job in a local charity, and while they didn't always chose to avail of this option, the opportunity was available to them.

Record keeping of activities required further improvement to ensure effective oversight as outlined under regulation 5, however there was clear evidence of improvement and a commitment from staff in this area. For example, there was a plan to introduce one of the residents to a new activity, and to assess whether this would be meaningful for them.

A new section had been introduced into person centred plans under the heading of 'My meaningful day' under which a list of activities that had been identified as meaningful for the resident was documented. A daily planner had been put in place for some residents, however, some of these lacked detail, and there was no documented evidence of adherence. In addition, record keeping in this area still

required improvement to ensure that the planned activities took place regularly.

The inspector found that the daily planner for the evening of one of the residents included communal activities, but that the resident spent the evening in their room. Whilst staff explained that on this occasion the resident had been on an outing for the day and needed to rest, a review of the documentation indicted that this was still the usual evening for this person, and that each evening was spent in their room, which was not in accordance with the plan which made allowance for a nap, but then included some interaction and presence in the communal areas of the house.

As mentioned earlier in this report, there had been an extra staff member put in place to support activation and inclusion of residents, but as this was unstructured it was unclear as to how effective this extra shift was.

Judgment: Substantially compliant

Regulation 17: Premises

Improvements had been made in the maintenance and upkeep of the premises. Painting had been completed inside and out, and additions to the internal decor had been made. The response of residents to some of these improvements is discussed in the first section of this report.

The required building work as agreed in the regulatory processes was underway. In particular a self-contained apartment was being built to accommodate the needs of one of the residents, and there was evidence that this resident was involved in the layout of their kitchen.

Other changes had been made included the storage within the house. All areas of the house were now uncluttered, and infection control issues identified on the previous inspecting relating to the storage of cleaning equipment and the swift disposal of incontinence products had all been addressed.

However, no progress had been made on making an outside cabin area available for the use of residents for activities or quiet time to ensure the safety of others should behaviours of concern arise. Whilst the current presentation of one of the residents who had previously posed a risk to others was well managed following interventions, the cyclical nature of their presentation meant that the risk was not yet fully mitigated in the long term, and the availability of the cabin was still a requirement.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

The previous inspection identified concerns reacting to the proposed move of a resident to a new home. This inspection found that all the concerns had been addressed, and that the resident had made a successful transfer to their new home.

Not only had all the required supports been put in place to ensure a smooth transition, staff from this centre were continuing to support the resident. The staff team had ensured that relationships with the friends of the resident in this centre had been maintained, and they were supporting and facilitating visits of residents to this person's new home, and ensuring that friendships were maintained.

Judgment: Compliant

Regulation 28: Fire precautions

During the inspection, the inspector observed that one of the fire doors was blocked because an item of equipment was being stored in front of it. On further investigation, the inspector found that the fire door had been locked because of the construction work that was taking place in the grounds of the centre.

There was a risk assessment in place which had identified the risk to residents should they use this door in the event of an emergency, and which determined that the lower risk was posed by the identification of a fire door which was located in the next compartment to be used in the event of an emergency. However, this protocol had not been checked or signed off by a competent fire safety professional, and when the centre had last been certified, this certification was based on access to all fire doors including the one which was now closed off. The most recent fire drill undertaken in the centre following the locking of the fire door found that, an evacuation of all residents would take nine minutes, so the inspector was not satisfied that best practice was in place to ensure the safety of resident in the event of an emergency.

In addition, a recent on-site fire training had resulted in a discussion about the potential requirement for one of the residents to be evacuated with the use of a ski sheet, rather than the 'sledge' that was in place, but this had not been followed up. The person in charge followed this up on the day after the inspection and submitted information that indicated that the use of a fire sheet would not be deemed appropriate.

Following the inspection assurances were made by the provider that access to the fire door in the event of an emergency was now assured, and that the concerns raised during the inspection had been addressed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

All the required actions identified at the previous inspection had been implemented. All staff were in recipe of refresher training and had familiarised themselves with the professional guidance document, and a clear record of this was maintained.

Staff support meetings had taken place in relation to any required actions, and the inspector observed clear records of the administration of any 'as required' medications, including the rationale for their use and documentation of the effect of the administration of medications.

There were improvements in the records of the administration of medications and supplementary feeds via percutaneous endoscopic gastrostomy (PEG). For example where there was a delay in administering a PEG feed, this was documented and the reason for the delay was recorded. The inspector spoke to two of the nurses who administer this type of feeding, and they described the learning that had taken place since the previous inspection.

In addition on this inspection there was evidence of a constant review of the medications prescribed to some residents, and where medication had been recently changed for one of the residents constant observations were undertaken to ensure positive outcomes for the resident. This included constant review by the relevant members of the MDT.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Significant improvements had been made in personal planning. Oversight of the personal planning system had resulted in all personal plans being reviewed and updated. There were identified staff members who took responsibility for each resident's personal plan.

These measures had resulted in much improved sections relating to daily activities. There was a section devoted to ensuring a meaningful day for each person, which identified preferred activities, and accounted for the specific needs of each resident. These sections of personal plans included detailed daily planners to ensure that staff were aware of the requirements for each resident to ensure a meaningful day.

For example, where a resident had particular needs relating to dementia care, there was a detailed daily planner which outlined meaningful activities for them, whilst allowing for frequently required rest times, although further development was required to ensure consistent implementation and recording of the plan.

The personal plans were now readily available to staff members, and in addition,

there were regular audits of personal plans undertaken by the person in charge in conjunction with the person participating in management.

However, improvements still required in the documentation of the implementation of plans to ensure consistency and to facilitate clear oversight, including the effectiveness, and to monitor the response or reaction of resident. There was a reliance on staff to make a written record of each person's day, and not all these records included information activities undertaken. There was sometimes a mention of activities, but not on a daily basis.

There was a section in each resident's personal plan relating to goals, as required by the regulations so as to ensure that the potential of each resident was maximised. However, not all of these goals were meaningful, and many of them were restricted to identifying activities for residents, without consideration being given to improving outcomes for residents. However, this had been identified by the team as being an area that required improvement, and progress towards this was still within the identified timeframe, and also within the timeframe submitted to HIQA via the monthly provider assurance reports.

In other sections of personal plans, improvements had been made, although further development was required in some areas. For example, where additional information had been included in the care plans for residents who required high levels of support in the provision of personal care, there was still insufficient guidance in place to inform staff as to the actions and interventions required from them to ensure the comfort of residents.

Judgment: Substantially compliant

Regulation 6: Health care

There were good practices in relation to healthcare for residents, and all the issues identified on previous inspections had been addressed.

There was a detailed plan of care in place for all healthcare issues, and where residents declined adhere to medical and nursing advice, this was clearly documented an risk assessed. The inspector had a chat with one of the residents about some of the healthcare issues, such as mobility and the suggestion that some equipment might be helpful. The resident clearly voiced their choice, and the reason for it, and was obviously well informed. The inspector found that their choice was an informed choice, and that the right of the resident to make their own decision was being respected.

Residents had good access to members of the multi-disciplinary team (MDT) and the recommendations of these professionals were available in each person's file.

There were various examples of healthcare issues having been identified and addressed, for example a recent change in bowel care for a resident had been

identified in a timely manner, and addressed appropriately through medication and diet. This had resulted in positive outcomes for the resident, both in terms of their physical health, and in an improvement in engagement and interest in activities.

Others had their medication under constant review, and again, this had resulted in improved outcomes for the individual, both in terms of their own mental health, and in their engagement with others in their shared home.

Judgment: Compliant

Regulation 9: Residents' rights

Improvements had been made in supporting and upholding the rights of residents. There were various examples of the rights of residents being respected, and of their choices being upheld. As reported previously in this report, residents were being supported to maintain their friendship with a resident who had recently moved to another residence. Others were being supported to engage in meaningful activities.

The dignity of all residents was well managed, and all staff engaged by the inspector spoke about the efforts that were underway to ensure the rights of residents were upheld. For example, various social stories had been developed to assist residents with understanding and communication. An example of this was a social story relating to the mobility aids previously mentioned in this report. The resident had clearly reviewed the information, and had signed the social story to say that they understood, and were still making their own decision.

There was a system whereby residents' meetings were to be held on a weekly basis. However, there were again irregularities in the consistency of these meetings, and they were not yet held every week.

A review of the records of these meetings indicated that only in the week prior to the inspection had the notes of these meetings indicated a meaningful discussion. However, this most recent record detailed the discussion, and included detail of the comments and observations of each resident. The person in charge undertook to ensure that this good practice would be continued each week henceforth.

Overall, significant improvements had been made, but further improvements were required to ensure that the additional staff member in the evenings in the centre would have positive outcomes for residents, and that records would provide information so as to ensure clear oversight that he rights of residents were upheld.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Avalon House OSV-0003694

Inspection ID: MON-0040839

Date of inspection: 11/10/2023

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A new template has been put in place that guides staff to document each activity offered and the resident's engagement or reaction to the activity to determine it meets the assessed needs of the resident. • The role of the staff member rostered between 20.00-22.00 has been clarified and a guidance document available to all staff in the handover folder to ensure the role is clearly defined and supports residents engagement in outings and meeting their psychosocial needs All activities offered by this staff member are to be recorded in the handover folder with each residents engagement reflected. • In relation to the cabin as use for sensory activation at a site meeting on 09.11.2023 the PIC was informed by the county council fire officer had requested photographs of the fire system and an outline of what the cabin was to be used for. No confirmation of a date of issue has been received. PIC and ADON will continue to work with property department to progress the certification of the cabin. • The other actions in relation to the provision of additional external storage space is being progressed in line with the timeframe submitted. Additionally, staff training on dementia and reviewing of resident goals continues and will be completed. • Construction work on the self-contained apartment continues and is on target with the agreed work schedule dates submitted.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: • A new template has been put in place that guides staff to document each activity offered and the resident's engagement or reaction to the activity to determine it meets the assessed needs of the resident. •	

• Resident's activity plans have been updated to reflect choice and preferred activities. Photographs are now taken regularly to show residents activities and outings. These will be printed and recorded in each resident's memory book if they wish to. Those who do not wish to complete a memory book will have it recorded in their person centered plan folder.
• The new template in place requires staff to document activities offered but not accepted by the resident to show residents choice to engage or otherwise.
• A new guidance document made available for staff with a log to record activities offered between 8pm and 10pm.
The role of the staff member rostered between 20.00-22.00 has been clarified and guidance document is available to all staff in the handover folder to ensure the role is clearly defined and understood.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
At a site meeting on 09.11.2023 the PIC was informed the county council fire officer had requested photographs of the fire system and an outline of what the cabin was to be used for. All the information requested was forwarded the Meath County Council fire officer on 10.11 2023 and we await the outcome.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Same was rectified 13.10.23. There is now a key lock in situ. All staff have a key to this as well as a key in a locked box both inside and out and the fire exit door is accessible as an escape route if required.

The fire evacuation needs of a particular resident have been addressed and the appropriate equipment to safely evacuate the resident is in place.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• A new template in place requires staff to document activities offered but not accepted by the resident to show residents choice to engage or otherwise.
• Training has been carried out with staff relating to documentation and goal planning on 26.10.23. A new template is being introduced to identify goals in relation to community, home life, activities and family to ensure they are meaningful.
• Further support has been obtained through the Mental Health ID occupational therapist to assist in addressing the sensory needs of the resident with a dementia diagnosis. Dementia training for the staff team occurred 14.11.2023.
• Audits of all residents' goals has been completed by the PIC with meetings to be carried out with each key working health care assistant by 17th November 2023.
• Health care plans have all been audited by CNM2 and ADON and staff currently working on new specific health care plans for residents as required.
• The skin integrity care plan in place, has been updated to guide staff on the interventions required.
• Further sessions of both trainings completed to be scheduled to ensure the full team receive both.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Meetings taking place weekly. Where required, staff meet with small groups at different times of the day to ensure all residents are involved. PIC/ADON reviewing minutes each week to ensure discussions occur and all documented appropriately. • The new activity template in place requires staff to document activities offered but not accepted by the resident to show residents choice to engage or not. New guidance document made available for staff with a log to record activities offered between 8pm and 10pm.	

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 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.	Substantially Compliant	Yellow	30/11/2023
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.	Substantially Compliant	Yellow	31/12/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Substantially Compliant	Yellow	31/12/2023

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	13/10/2023
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	31/01/2024
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his	Substantially Compliant	Yellow	30/11/2023

	or her care and support.			