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:	Bird Hill
Name of provider:	St Catherine's Association Company Limited By Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	21 April 2022
Centre ID:	OSV-0005660
Fieldwork ID:	MON-0032775

About the designated centre

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

Birdhill designated centre is operated by St. Catherine's Association. The provider had described the designated centre as a bespoke property located in a rural part of County Wicklow but within a short driving distance from local amenities and towns. The property provides residents with scenic views of the local countryside, it is modern and comfortable throughout. The centre has a capacity for two residents and provides services to adults with intellectual disabilities and autism. The centre is managed by a person in charge who also has a remit for two other designated centres that are located within a short distance from each other.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 21 April 2022	09:30hrs to 18:15hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The provider and person in charge were endeavouring to ensure that the residents living in the centre were in receipt of a good quality service.

On the day of the inspection, the inspector met the two residents living in the centre. Both residents were on a mid-term break from their community day service. Engagements between the inspector and the two residents took place, (as much as possible), from a two metre distance and wearing the appropriate personal protective equipment (PPE) in adherence with national guidance. While the residents greeted and engaged briefly with the inspector, overall, the residents did not communicate their views of the service to the inspector. However, the inspector observed the residents to appear happy and content in their home and be relaxed and comfortable in their environment and when engaging with staff.

The inspector observed that the residents' living environment provided appropriate stimulation and opportunity for the residents to engage in recreational and sensory activities. The house was well equipped to meet the residents' sensory needs. For example, there was a separate sensory room located adjacent to the main house which included a variety of sensory equipment in line with the residents likes and wishes. In the main house, in the sitting room, there was also a number of games and sensory objects available to the residents. Overall, the inspector observed the house to be clean and tidy however, some improvements were needed to the upkeep and state of repair to some areas of the house. This was to ensure that residents were living in an environment that was in good decorative and structural repair and mitigated the risk of infection, at all times.

Residents were encouraged and supported around active decision making and social inclusion. Where appropriate, residents were encouraged to complete household tasks in their home. For example, completing laundry tasks. Residents enjoyed going for walks in local parks, eating out in local cafes and restaurants and attending the local equestrian centre for horse riding lessons. However, the inspector found, that at times, due to insufficient staffing levels on the day, residents' planned activities had to be postponed.

The inspector found that the health and wellbeing of each resident was promoted and supported in a variety of ways including through diet, nutrition, recreation, exercise and physical activities. Staff were mindful and respectful in supporting residents with specific dietary and eating requirements. Residents were provided with a choice of healthy meal, beverage and snack options which were recorded in their personal plan. Treats were also available to residents such as takeout meals and a wide variety of snacks options.

In summary, through speaking with management and staff and through observations, the inspector found that it was evident that staff and the local management team were striving to ensure that residents lived in a supportive and

caring environment. However, some improvements were needed in areas relating to staffing levels, premises and restrictive practices. These are addressed in the next two sections of the report which present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The registered provider was striving to ensure that the residents living in the designated centre were in receipt of a good quality and safe service. There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a deputy manager, who was knowledgeable about the support needs' of the residents and this was demonstrated through good-quality care and support. However, on the day of the inspection, the inspector found that a number of improvements were needed and in particular, to ensure that there were sufficient staff available at all times to allow the effective delivery of care and support to residents living in the centre.

The provider had not ensured that the number of staff was appropriate to the number and assessed needs of the residents at all times. On review of the March and April 2022 staffing roster, the inspector found that there were a number of days where the staffing levels were insufficient to meet the assessed needs of the residents. This had resulted in residents missing out on planned activities, attending planned medical appointments and on occasion, limited access to individualised activities. On review of other documentation and through discussion with staff, the inspector found that this issues had also arisen during 2021. For example, the complaints log demonstrated that a resident's preference to go to the shops could not be accommodated due to inadequate staffing levels on the day. There was no relief panel system in place in the centre. The inspector was advised that, where there were unexpected absences, the current staff team would endeavour to cover shifts however, this was not always possible. The inspector was advised that the provider is activity and continuously recruiting staff. On speaking with the person in charge and person participating in management regarding the staffing levels, the inspector acknowledged the challenges in managing services and supporting residents during the current health pandemic.

Notwithstanding the above, the inspector observed that there was a staff culture in place which promoted and protected the rights and dignity of the residents through person-centred care and support. Staff were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre. The inspector observed that staff were engaging in safe practices related to reducing the risks associated with COVID-19 when delivering care and

support to the residents.

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained. A training matrix was maintained which demonstrated that staff were provided with both mandatory and refresher training. However, on the day of inspection, the inspector found that a number of staff refresher training courses were overdue and some staff had yet to complete full training courses. Staff were provided with one-to-one supervision meetings with the deputy manager, to assist them perform their duties to the best of their ability when supporting residents. Staff who spoke with the inspector advised that they found these meeting to be supportive and beneficial to their practice.

The provider had completed an annual report in June 2021 of the quality and safety of care and support in the designated centre. During 2020, the centre's management had carried out two six monthly reviews of the centre and completed a written report on the safety and quality of care and support provided in the centre. The provider had also completed a six monthly unannounced review of the centre in October 2021 and subsequent to the inspection, the draft version of the April 2022 review was submitted to the inspector. In addition, there was a local auditing system in place completed by the deputy manager with oversight of the person in charge.

The provider had completed the Health Information and Quality Authority (HIQA) preparedness and contingency planning self-assessment for designated centres for adults and children with a disability for a COVID-19 outbreak, which was regularly reviewed by the person in charge. Furthermore, the provider had put in place an COVID-19 outbreak response plan for the centre which included appropriate precautions such as contingency plans, self-isolation plans and infection prevention control checklists in place during the current health pandemic. However, improvement were required to ensure that the plan was updated on a more regular basis and in particular, updated in line with changes in national guidance. For example, the content of the PPE requirement table was not in line with the most up-to-date guidance.

The inspector found that the information governance arrangements in place to ensure that the designated centre complied with notification requirements required improvement. For example, not all restrictive practices used in the centre were notified to the Chief Inspector on a quarterly basis. In addition, where residents had incurred non-serious injuries, these had not been notified as required.

There was a complaints policy and procedure which was readily available and accessible to residents. There were systems in place to monitor the complaints procedure for effectiveness, including outcomes for residents. The inspector reviewed the complaints log and saw that a small number of complaints had been made in 2021. Overall, the complaints were followed up in a timely manner. However, improvements were needed to ensure that the complaints log and individual complaint forms were fully completed at all times. For example, some of the forms had not been completed sufficiently to demonstrate if the complaint had been fully resolved. In addition, some forms had not included the name of the

person who made the complaint, or the name of the person who supported the resident to make the complaint. None of the forms reviewed included if the complainant was satisfied with the outcome or not. Most of these matters had been identified by the provider in the October 2021 six monthly review however, on the day of the inspection, the above mentioned issues remained outstanding.

Regulation 15: Staffing

The staffing arrangements in place in the centre were not sufficient, (at all times), to meet the assessed need of residents which resulted in negative outcomes for residents. For example, there were occasions where residents missed out on planned activities, medical appointments and limited their access to individualised activities.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were provided with training in safeguarding, fire safety, managing behaviours that challenge, infection prevention and control, safe medicine practices and food hygiene but to mention a few. Training was regularly reviewed and monitored by the person in charge. However, on the day of the inspection, the inspector found that a number staff had yet to complete refresher training courses and for some new staff, training courses. For example; Fire safety training – one staff; First Aid training - four staff; Intimate care training - one staff, managing behaviours that challenge - two staff refresher and two staff fully course; Safe medicine practices - one staff full course; online training in infection prevention control and anti-microbial stewardship training (AMRIC) - two staff had not completed all modules of this training course.

Supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability.

Judgment: Substantially compliant

Regulation 23: Governance and management

For the most part, the provider and person in charge had satisfactory governance and management systems in place within the designated centre to monitor the safe delivery of care and support to residents. However, improvements were needed to

address the following issues.

The provider had not ensured that, the number of staff was appropriate to the number and assessed needs of the residents, at all times.

The centre's COVID-19 outbreak response plan required updating on a more regular basis and in particular, so that it was in line with national guidance.

The information governance arrangements in place to ensure that the designated centre complied with notification requirements required improvement so that all non-serious injuries and restrictive practices were reported to HIQA as required.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector found that the information governance arrangements in place to ensure that the designated centre complied with notification requirements required improvement. For example, not all restrictive practices used in the centre were notified to the Chief Inspector on a quarterly basis. In addition, where residents had incurred non-serious injuries, these had not been notified as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure which was readily available and accessible to residents. The was a small number of complaints made in 2021. Overall, the complaints were followed up in a timely manner. However, improvements were needed to ensure that the complaints log and individual complaint forms were fully completed at all times.

Judgment: Substantially compliant

Quality and safety

For the most part, the inspector found that the residents' well-being and welfare was maintained by a good standard of evidence-based care and support and that there was a strong and visible person-centred culture within the centre. The person in charge and staff were aware of each of the resident's needs and knowledgeable

in the care practices to meet those needs. However, improvements were needed to the general maintenance and upkeep of the centre so that it ensured residents were living in an environment that was in good state of repair, safe and mitigated the risk of infection. Furthermore, improvements were needed to ensure that where restrictive practices were used, they were in line with national policy and best practice and were the least restrictive for the shortest duration.

The provider promoted a positive approach to behaviours that challenge. Residents were provided with positive behaviour support plans which were regularly reviewed. The inspector found that the systems in place to record non-serious injuries, which related to behaviours that challenge, required review. Where a number of non-serious injuries had occurred, due to residents' self-injurious behaviours, they had been recorded in each resident's daily log. However, improvements were needed to this system to ensure better clarity of when the injuries had occurred and how they were followed up. In addition, non-serious injuries had not been notified to HIQA on a quarterly basis as required. There were other non-serious injuries recorded on the centre's health and safety incident forms, which were not necessarily related to residents' behaviour however, these also had not been notified to HIQA.

During the walk-around of the centre the inspector observed a number of environmental restrictions in place such as locked drawer, cupboards and doors. The inspector found that not all restrictive practices were guided by the centre's restrictive procedure's policy and were not in line with national policy and evidence based practice. For example, there was no rationale for the restrictions included in the resident's person plans. In addition, an appropriate risk assessment had not been completed and the restrictions had not been logged when in use, or notified to HIQA on a quarterly basis as required. As such the provider could not be assured, if these restrictions were the least restrictive for the shortest duration.

There was an up-to-date safeguarding policy in the centre and it was made available for staff to review. Staff had received up-to-date training in the safeguarding and protection of vulnerable adults. Staff spoken with appeared familiar with reporting systems in place, should a safeguarding concern arise. Staff facilitated a supportive environment which enabled the residents to feel safe and protected from abuse. The provider and person in charge had put in place safeguarding measures to ensure that staff providing personal intimate care to residents, who required such assistance, did so in line with each resident's personal plan and in a manner that respected each resident's dignity and bodily integrity.

The provider had notified HIQA of a behavioural incident that occurred in the centre in 2021. Two incident reports were completed and reviewed by the centre's management. In addition, residents' positive behaviour support plans were reviewed and learning from the incident was shared at the staff team meeting. However, the inspector found that no preliminary screening had been completed or submitted to the Safeguarding and Protection Team. In effect, this meant that the process had not been implemented in line with the Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures.

The inspector reviewed the residents' personal plans and saw that they included an

assessment of each resident's health, personal and social care needs and that overall, arrangements were in place to meet those needs. This ensured that the supports put in place endeavoured to maximise each resident's personal development in accordance to their wishes, individual needs and choices. Both residents' personal plans noted that they had been updated in October 2021 however, on review of the plans, the inspector found that improvements were needed to clearly demonstrate their review. For example, the 'about me' section included more detail on a resident's previous day service than their current one. The family section included information relating to 2017 and 2019, the significant life events section included information relating to 2018 with a gap until 2021. The communication section and other services section did not clearly demonstrate any reviews or updates that had taken place. The profile photograph on a resident's profile 'All about me' section, had not been updated in line with the other recent photograph's that were contained in their plan. There was also improvement needed to ensure that residents' personal plans were made available to them in an accessible format to support the residents better understand them.

Overall, the register provider had ensured that residents were assisted and supported to communicate in accordance with their needs and wishes. Each resident had been provided with an assessment of their communication needs, preferences and wishes. Residents had access to electronic devises, television and internet. The inspector observed that the residents seemed relaxed and happy in the company of staff and that staff were respectful towards the residents through positive, jovial and caring interactions. On observing the residents interacting and engaging with staff, the inspector saw that staff could interpret what was being communicated by the residents. Staff who spoke with the inspector demonstrated good understanding of the residents' communication needs and how to support their needs. Where appropriate, residents were facilitated and supported to communicate with their families and friends in a way that suited them. When required, residents were supported to understand matters through easy reads, social stories and use of visual aids. Overall, information provided to residents was in a format that they understood however, a small improvement was needed to a daily visual planner on the kitchen notice board to ensure that it was age appropriate for the residents living in the centre.

Residents were encouraged to eat a varied diet and were communicated about their meals and their food preferences. The inspector found there to be adequate amounts of wholesome and nutritious food and drink available to the residents. Residents food and nutritional needs were assessed and used to develop person centred plans that were implemented into practice. Where required, there were supports in place to ensure that all residents could enjoy eating their food as independently as they were capable of. For example, one residents, in line with their assessed needs, was provided with a special type of plate that enabled them to eat with minimum assistance. On speaking with staff, the inspector found, that at times when a resident needed assistance to cut up their food, staff offered help in a respectful and dignified way alongside promoting their independence. Overall, the inspector observed the residents' food and drink to be stored in hygienic conditions and that there were systems in place to monitor the appropriate storage of food and

drink, such as temperature checks and cleaning schedules.

The provider had ensured that there was a risk register in place in the centre with associated centre and individual risk assessments completed. There were risk assessments specific to the current health pandemic including, the varying risks associated with the transmission of the virus and the control measures in place to mitigate them. On the day of the inspection, the inspector was advised that the provider was completing a review of risk register to ensure the appropriate risk rates were applied to all risk assessments in place.

The inspector observed that the design and layout of the designated centre ensured that the residents could enjoy living in an accessible, comfortable and for the most part, homely environment. This enabled the promotion of independence, recreation and leisure. The centre provided appropriate indoor and outdoor recreational areas for the residents, including age-appropriate play and recreational facilities. There was a maintenance logging system in place, and on review of the log, the inspector saw that the majority of tasks had been completed in a timely manner. However, on the day of the inspection, during a walk-around of the centre, the inspector observed a number of repairs required to the premise. Many of these repairs had been identified by local management in early April 2022 however, there was no plan or time frame in place to complete them. Some of the maintenance work impacted on the centre's infection prevention and control measures in place. For example, disrepair of the centre's counter tops, flooring, windows and bathrooms, meant that they could not be cleaned effectively and potentially increased the risk of spread of infection in the centre.

Overall, the house was observed to be clean and cleaning records demonstrated that staff were working in line with the cleaning schedules in place in the centre. The inspector observed there to be adequate supply of hand sanitizer, hand washing facilities and soap for staff and residents to use and there was ready access to an ample supply of PPE gear. The inspector found that there were satisfactory contingency arrangements in place for the centre during the current health pandemic including self-isolation plans for residents, an outbreak response plan and numerous protocols to ensure the safety of residents. The majority of staff had completed specific training in relation to the prevention and control of COVID-19. Residents were kept informed about matters relating to COVID-19 in ways that met their communication needs. For example, there were a number of social stories comprised for residents to support their understand of the current health pandemic.

Regulation 10: Communication

Overall, the register provider had ensured that resident were assisted and supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 17: Premises

There was a number of upkeep and repairs required in the centre. In early April 2022 the local management completed a list of repair work required in the centre. However, on the day of the inspection, there was no plan or time frame in place for the work to be completed.

On the day of the inspection, the inspector observed the following (some of which had been included on the provider's maintenance list).

Repair work was needed to the kitchen and dinning room floor area which was badly scuffed and damaged in areas.

The laminate on the kitchen counter was in disrepair and exposing the wooden surface underneath.

The sealant around the bath in a downstairs bathroom was grubby. In addition, the sealant and grout in both residents' en-suites required upkeep.

The location and use of the plug-in radiator in the sensory room required review; on the day of the inspection the room was very warm and stuffy.

The laundry room ceiling was covered in cobwebs and spiders. The laminate on the counter top beside the sink in the laundry was chipped and exposing the wooden surface underneath.

The paint on the windows in both residents' bedrooms was peeling in sections and for one window, the rubber seal had come loose.

There were two concrete slaps to the side of the house which posed as a trip hazard as the surface around them was uneven.

The large glass doors exiting the sitting room were stiff and heavy. The inspector was advised that residents found it difficult to open these doors independently because of this.

The floor covering on the stairway was clinical in nature and took away from the homeliness of the house.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector found there to be adequate amounts of wholesome and nutritious

food and drink available to the residents. Residents' food and nutritional needs were assessed and used to develop person plans that were implemented into practice.

Judgment: Compliant

Regulation 27: Protection against infection

The inspector found that there were contingency arrangements in place for the centre during the current health pandemic including self-isolation plans for residents, an outbreak response plan and numerous protocols to ensure the safety of residents.

Overall, the house was clean and cleaning records demonstrated that staff were working in line with the cleaning schedules in place. However, due to the state of repair of some areas of the premises, not all areas of the centre could be cleaned effectively and potentially increased the risk of spread of infection to residents and overall, impacted on the effectiveness of some of the infection prevention control measures in place. (This has been addressed under Regulation 17).

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Both residents' personal plans noted that they had been updated in October 2021 however, on review of the plans, the inspector found that improvements were needed to clearly demonstrate their review.

There was also improvement needed to ensure that residents' personal plans were made available to them in an accessible format to support residents better understand them.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that the systems in place to record non-serious injuries, which related to behaviours that challenge, required review. The recording system of some non-serious injuries made it difficult to ascertain when they had occurred and how they were followed up. In addition, these non-serious injuries, and others included in the centre's health and safety incident forms, had not been notified to HIQA on a

quarterly basis as required.

There was a number of environmental restrictions being used in the centre. There was a locked cutlery drawer, a locked food cupboard, a locked storage cupboard and the door to the laundry room was locked. These restrictive practices were not guided by the centre's restrictive procedure's policy and were not in line with national policy and evidence based practice. For example,

(1) The rationale for some restrictions had not been included in either of the resident's person plans.

(2) An appropriate risk assessment, specific to some of the restrictions had not been completed.

(3) Not all restrictions had been logged when in use or notified to HIQA as required.

As such the provider could not be assured, if these restrictions were the least restrictive for the shortest duration.

Judgment: Not compliant

Regulation 8: Protection

The provider had notified HIQA of a behavioural incident that occurred in the centre in 2021. However, no preliminary screening had been completed or submitted to the Safeguarding and Protection Team. In effect, this meant that the process had not been implemented in line with the Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Bird Hill OSV-0005660

Inspection ID: MON-0032775

Date of inspection: 21/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Conduct a root and branch review of staffing levels in line with the needs of the residents. Once completed there will be two courses of action; either update the Statement of Purpose to reflect the revised whole time equivalents required to provide a safe and effective service or actively hire for additional staff. An agency is in use to support current staffing deficits. The agency staff person used is consistent and known to the residents. PIC to negotiate with the relevant agency to see if they can support 30 hours per week until end of July.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1 Staff – Fire Safety – one to one training to be completed 7/6/22 4 staff – First Aid – 1 completed on 13/4/22, 3 scheduled for 22/6/22 1 staff – Intimate Care Training – Completed on 26/5/22 2 staff – MAPA/Safety intervention refresher – 1 scheduled 9/6/22, 1 scheduled 16/6/22 1 staff – SAMS full course booked 14-16/6/22 2 staff – Online training in AMRIC – 2 completed by 31/5/22	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider had not ensured that, the number of staff was appropriate to the number and assessed needs of the residents, at all times. – Conduct a root and branch review of staffing levels in line with the needs of the residents. Once completed there will be two courses of action; either update the Statement of Purpose to reflect the revised whole	

time equivalents required to provide a safe and effective service or actively hire for additional staff.

An agency is in use to support current staffing deficits. The agency staff person used is consistent and known to the residents. PIC to negotiate with the relevant agency to see if they can support 30 hours per week until end of July.

The centre's COVID-19 outbreak response plan has been updated and adjusted to reflect national guidance. This was completed on the 26/5/22.
The PIC has submitted the quarterly notifications in line notification requirements and a measure has been put in place to ensure these quarterly notifications continue to be submitted in a timely manner. Completed 28/4/22.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Completed 28/4/22, PIC will schedule in diary moving forward

Staff will use the H&S Form to note SIB that does not result in an injury but is observed and all H&S forms will be reviewed with Positive Behaviour Support Specialist.

New Risk Assessment was completed in relation to the locking of a cleaning press in the kitchen and the outside utility room, with the restrictions removed. Completed 26/4/22

A new Risk Assessment was completed in relation to the locking of a cupboard containing nuts. Completed 19/5/22

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
PIC to do a review of the complaints to identify deficits, have 1 to 1 meeting with the relevant staff and to include in monthly staff meeting.

Head of Operations to include review of Complaints in monthly CSM/DCSM meeting

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Repair work was needed to the kitchen and dinning room floor area which was badly scuffed and damaged in areas. - Quote to be obtained for replacement of floor and to be submitted as part of a business plan to funder.
The laminate on the kitchen counter was in disrepair and exposing the wooden surface underneath. - Quote to be obtained for replacement of counter top and to be submitted as part of a business plan to funder.
The sealant around the bath in a downstairs bathroom was grubby. In addition, the sealant and grout in both residents' en-suites required upkeep. - Maintenance has been informed of the works and work is being scheduled for completion.

The location and use of the plug-in radiator in the sensory room required review; on the day of the inspection the room was very warm and stuffy. – The radiator has been moved to other side of the room and temperature on unit has been reduced. However this is the temperature and ambiance that the resident prefers.
The laundry room ceiling was covered in cobwebs and spiders. The laminate on the counter top beside the sink in the laundry was chipped and exposing the wooden surface underneath. – Laundry room ceiling has been cleaned. Obtain quote to replace counter top and submit as part of a business plan to funder.
The paint on the windows in both residents' bedrooms was peeling in sections and for one window, the rubber seal had come loose. - Maintenance has been informed of the need to fix rubber seal and this work is being scheduled for completion. Quote to be obtained for replacement windows and to be submitted as part of a business plan to funder.
There were two concrete slaps to the side of the house which posed as a trip hazard as the surface around them was uneven. - Maintenance to review and level area. Work is being scheduled for completion.
The large glass doors exiting the sitting room were stiff and heavy. The inspector was advised that residents found it difficult to open these doors independently because of this. - Quote to be obtained for replacement doors and to be submitted as part of a business plan to funder.
The floor covering on the stairway was clinical in nature and took away from the homeliness of the house. - There had been carpet on the stairway previously but it was removed due to the assessed needs of one of the residents due to them having Cerebral Palsy. The current covering is in place to address this need and that of IPC.

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:
The personal planning committee is resuming following limited access due to Covid. The focus of the committee will be to review the organization personal care plans template to address the need for annual reviews and the efficacy of the current review process.

The committee will also be reviewing the accessibility of personal care plans for the residents.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
New Risk Assessments completed on the 26/4/22 and 19/5/22.

Maintenance to review locked cupboard to see if it can be made into two cupboards to reduce restriction on the other resident that does not have the allergy.

Restrictions needed to be put into both Care Plans, completed 19/5/22

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Complete – HOO engaged the HSE Safeguarding and Protection Team on 27th April 2022. HOO submitted a Preliminary Screening Form (PSF) on 28th April 2022. HSE Safeguarding and Protection Team provided feedback on 4th May, and HOO submitted an updated PSF on 10th May. HSE Safeguarding and Protection confirmed the following on 11th May; "I will now close this incident to the safeguarding team on the basis that the safeguarding plan is in place and remains a live document."	

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.	Not Compliant	Orange	30/06/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	16/06/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/06/2022

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/06/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	28/06/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure	Not Compliant	Orange	28/04/2022

	including physical, chemical or environmental restraint was used.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	28/04/2022
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	30/06/2022
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/09/2022
Regulation 05(6)(c)	The person in charge shall	Substantially Compliant	Yellow	30/07/2022

	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 assess the effectiveness of the plan.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	19/05/2022
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	19/05/2022
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take	Substantially Compliant	Yellow	11/05/2022

	appropriate action where a resident is harmed or suffers abuse.			