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:	DC2
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	22 March 2024
Centre ID:	OSV-0002934
Fieldwork ID:	MON-0034780

About the designated centre

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

DC2 is a designated centre for adults with intellectual disabilities operated by St. John of God Kildare Services. The centre is located in a congregated campus setting situated in a town in County Kildare. The centre comprises of two residential bungalows beside each other. One of the bungalows has the capacity for five residents and the other bungalow has capacity for four residents. The designated centre can provide residential services for adults both male and female with intellectual disabilities with additional healthcare and behaviour support needs. The centre is managed by a person in charge who is supported by a senior manager. The staff team comprises of nurses with health and social care workers also working in the centre to support residents.

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
Friday 22 March 2024	09:35hrs to 18:30hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, on the day of the inspection, the inspector observed that residents living in this designated centre were supported by staff who understood and supported their needs. A number of improvements were required in relation to fire precautions. Additionally, some improvements were required in relation to staffing, training and staff development, governance and management, and medicines and pharmaceutical services. These areas are discussed further in the next sections of the report.

The inspector had the opportunity to meet all eight of the residents that lived in the centre. The centre was made up of two houses beside one another on a campus based setting. Two residents attended a day programme between Monday to Friday that was external to their centre. One resident spoke with the inspector and communicated that they were happy and said that the house, the food and the staff were nice. Some residents just briefly said hello to the inspector but greeted them warmly to their home with hand shakes or hugs. Some residents, with alternative communication methods or limited verbal communication, did not share their views with the inspector, and were observed at different times during the course of the inspection in their home.

Two residents walked to the village and went out for lunch. Two residents attended what the person in charge called 'the hub' for a few hours. The hub consisted of three rooms on the campus that the person in charge had arranged to be renovated and used as a space for residents to complete activities out of their home. While at the hub the residents played some sports and did some art. The remaining two residents relaxed in their home for the day listening to music.

In addition to the person in charge, there were three staff members on duty during the day of the inspection. Two staff members worked in each house each day. The inspector observed gentle and friendly interactions between staff members and residents. For example, one staff member was observed sitting colouring with a resident and they joked about how the resident prefers to watch staff colour rather than colour themselves. The person in charge then joined in the jovial interaction to say that the resident should have shares in a particular shop that sold the art supplies as they shop there that often.

The provider had arranged for staff to have training in human rights. The inspector spoke with one staff member and they were asked how they were putting that training into everyday practice to promote the rights of the residents. One staff member spoken with said that, in the past they would have made some decisions for the residents that they supported. For example, they would have gotten out clothes for the resident to wear based on the weather. Now they ensure that they involved the resident in the decision and ensure their choice is upheld.

For the most part, the house appeared clean and tidy. There was sufficient space for

residents to have privacy and recreation. There were televisions and art supplies available for residents to use. There was a poly tunnel in the back garden of one house that the person in charge said that residents grow vegetables in during the summer months. It was currently not in use at the time of this inspection.

Each resident had their own bedroom and there was adequate storage facilities for their personal belongings. Each room appeared to be decorated as per the residents' preferences. For example, one resident loved cars and had cars displayed in lots of areas of their room. They proudly showed off the cars to the inspector. Another resident had a record player in their room as they loved to relax listening to music on their records.

The provider had recently sought family views on the service provided to them by way of questionnaires. Communication received appeared very positive. For example, a family representative stated that they were very happy with the care and attention their family member received. Another commented that their family member was always well groomed and they as a family feel welcome in the centre.

As part of this inspection process residents' views were sought through questionnaires provided by the Health Information and Quality Authority (HIQA). Feedback from the questionnaires returned was provided by way of staff representatives. The questionnaires indicated that the residents were happy with the majority of the areas discussed in the document. They related to their home and the care and supports they receive in the centre. Some residents would like to be included more in decisions that are made about their home. One resident's questionnaire stated that they would like improvement in what they do each day and another stated that they would like more food choices. The inspector discussed the outcome of the questionnaires with the person in charge who planned to discuss same with the residents and staff that worked in the centre.

The inspector had the opportunity to speak with a family representative of a resident that attended the centre on the day of the inspection to visit their family member. They communicated that they were happy with the service. They said that they had no concerns about the care their family member received. They said that they would be comfortable bringing any concerns if they had any to the person in charge.

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

Capacity and capability

This inspection was undertaken following the provider's application to renew the registration of the centre. This centre was last inspected in May 2022 where an infection protection and control (IPC) inspection was undertaken. It was observed at

that inspection that for the most part there were good arrangements and practices in place to manage infection control risks. Any actions from the previous inspection had been completed by the time of this inspection.

The findings of this inspection indicated that the provider had the capacity to operate the service in compliance with S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations) and in a manner which ensured the delivery of care was safe and of good quality.

The provider had completed an annual review and unannounced visit to the centre as per the regulations. There were other local audits and reviews conducted in areas, for example personal plans and IPC. However, some improvements were required in relation to the oversight of some audits and in the completion of some actions identified.

There were adequate staff available, with for the most part the required skills and experience to meet the assessed needs of residents. However, on occasion residents' ability to leave the campus setting was impacted due to staffing levels and some staff members not having training in epilepsy.

The inspector found that while there were supervision arrangements in place, formal supervision was not happening at a frequency described in the provider's policy. There were systems in place to monitor staff training and development. The provider had ensured that staff had access to necessary training in order to support the residents, for example staff had received training in relation to eating, drinking and swallowing. However, some staff training was required, for example in relation to some IPC trainings and other training was observed not to happen in a timely manner. In addition, improvements were required to the training oversight document to ensure it was reliably maintained.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced. They were employed in a full-time capacity managing this centre.

Staff members spoken with communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns and they felt they would be listened to.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual roster maintained by the person in charge. The inspector reviewed the current staff roster and a sample of some of the previous rosters. It was found that the provider had ensured that safe staffing levels were maintained to meet residents' assessed needs.

However, from speaking with some staff and from a review of records, staffing levels on occasions affected some residents' opportunities to leave their home to take part in external activities. Staffing levels at times restricted the length of time that could be spent taking part in activities due to staff being required elsewhere to support another resident within the centre. In some cases when residents did leave their home they did not leave the campus setting. For example, from the evidence provided to the inspector, on a sample of one week, one resident did not leave their home for three days and only left the campus setting on one day.

In addition, health care assistants were not provided training in epilepsy or emergency medication. This had the potential to affect residents' ability to go on external activities if a nurse was busy at the time. The residential coordinator communicated to the inspector that this training was already being considered by the organisation for health care assistants.

A sample of staff personnel files were reviewed on this inspection. The inspector found that not all information was evident within the files. For example, some references and one staff member's employment history could not be sourced. Some identification was found to be expired; however, the person in charge arranged for up-to-date identification to be sourced and filed on the day of the inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had arrangements in place for staff to have a suite of training in order to safely support the residents. For example, staff had training in fire safety, manual handling, and eating, drinking and swallowing training. Staff had received additional training to support residents, for example staff had received training in human rights. Further details on this have been included in what residents told us and what inspectors observed section of the report.

However, from a review of the training oversight document and a sample of staff certification, the inspector found not all training was up to date. They related to:

- seven staff required hand hygiene refresher training
- all staff required standard and transmission based precautions training
- all staff required respiratory hygiene and cough etiquette training.

In addition, it was not clear if some staff had certain training due to the fact that the oversight document was left blank in some sections, for example personal protective equipment (PPE) training. The inspector only able had access to two staff members'

certificates and both required refresher training.

In the case of safeguarding training, the oversight document indicated that three staff members' training was expired. However, the person in charge communicated that to the best of their knowledge that the staff members had completed refresher training in this area. This meant that records were not always reliably maintained and would make it difficult to provide effective oversight of the staff training needs in the absence of up-to-date information.

All staff members either had cardiac first response training or were scheduled to receive it at the end of May. However, one staff member's training was observed to be expired several months. This meant that staff members did not always have access to refresher training in a timely manner in order for them to safely support the residents.

Four staff members required training in how to operate a ski-sled to support a resident in the event of an emergency at night. The person in charge confirmed that the training would be occurring in the coming weeks.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a defined management structure in place which included, the person in charge and the residential coordinator for the organisation, who was the person participating in management for the centre.

The provider had arrangements for unannounced visits and an annual review of the service to be completed. There were other local audits and reviews conducted in areas and a schedule was set out for the year. For example, audits completed related to fire safety, medication and finances.

The person in charge was found to be completing all of their rostered hours working with the residents in the centre and they had no protected management time. While they appeared for the most part to be managing their time well, this had the potential to impact on their ability to provide appropriate managerial oversight.

For example, it was not evident that some actions from audits were being followed up on. For instance, a financial audit identified that bank statements had not been compared to the residents' expenditures records for oversight and this was not completed retrospectively when this was observed. Additionally, there was no evidence to suggest to the inspector that there was oversight of the health and safety checks completed by staff as mentioned further in this report. For instance, from the records reviewed no weekly checks were completed from 2023 to date and there was no follow up completed with staff.

In addition, supervision was not occurring in line with the provider's policy. This was

self-identified by the provider on their audits. It was communicated to the inspector that this was due to the time restraints on the person in charge.

Furthermore, while there were periodic staff meetings they were not happening every two months as the person in charge communicated they should be. The inspector observed that four staff meetings took place in 2023 and one in 2024 to date.

Judgment: Substantially compliant

Quality and safety

Overall, the residents were receiving care and support which was in line with their assessed needs. However, as previously stated improvements were required to fire precautions and some improvements were required to medicines and pharmaceutical services.

There were fire containment and management measures in place. For example, there were regular fire evacuation drills taking place and firefighting equipment was available, and regularly serviced. However, a number of improvements were required to be in compliance with this regulation. Improvements required related to some fire containment doors, the external emergency lighting for the centre, fire safety checks, evacuation drills, and the fire evacuation procedures to ensure it adequately guided staff.

Residents' health and social care needs were assessed and there were personal plans in place for identified areas the residents required support in. For example, residents had a document called 'all about me' to help guide staff to what supports they required and what was important to the resident. Residents were supported with their communication. For example, through the use pictures and in some cases through communication devices.

The inspector reviewed the arrangements for the use of restrictive practices and while there were some in place, for example a lap belt for a wheelchair, they were kept under regular review. In addition, where required, residents were supported to manage their behaviour positively, for example staff were appropriately training.

From a review of the safeguarding arrangements in place, the provider had safeguarding arrangements in place to protect residents from the risk of abuse. For example, staff had received training in adult safeguarding.

The centre had appropriate risk management procedures in place. For example, there was an organisational risk management policy in place.

For the most part, the inspector observed each premises to be clean and in a good state of repair. There were some minor areas identified that required improvement.

The majority of which were addressed on the day of the inspection, for example a bathroom shelf was repaired due to part of it being worn.

For the most part, the inspector found that there were suitable arrangements in place with regard to the ordering, receipt and storage of medicines. However, improvements were required to the system for disposal of medicines deemed no longer required. In addition, two residents prescribing documents required more information with regard to a specific medication. This was to ensure staff were appropriated guided to administer it as prescribed.

Regulation 10: Communication

There were communication profiles in place for each resident. Staff used some pictures to support residents to make informed choices about their day. Two residents were in the process of receiving weekly speech and language input. Communication devices were recently induced in order to support two residents' communication. The speech and language therapist was building upon each resident's use of the device and supporting staff to become comfortable using the device.

In addition, the provider had arranged that the speech and language therapist would guide staff to support residents' communication using a checklist of communication competencies. Additionally, the residents had access to televisions, phones and Internet within the centre.

Judgment: Compliant

Regulation 17: Premises

The premises was for the most part found to be clean and in a good state of repair. The inspector observed some minor areas that required improvement in order to ensure that all areas in the centre could be properly cleaned. For example, in one house there was noticeable limescale build-up around a tap in the bathroom. The inspector observed that the surface was peeling on the side of a press in the kitchen of the other house. The person in charge arranged for the majority of the identified areas to be addressed on the day of the inspection and assured the inspector that the remainder would be completed within the week. They then verbally communicated to the inspector post inspection that any premises issues had been addressed.

The centre had adequate space for the residents to have recreation and space and the garden had seating available.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place to manage and mitigate risk and keep residents safe in the centre. For example, there was a policy on risk management available. Risk management arrangements ensured that risks were identified, monitored and regularly reviewed.

There was a risk register in place in order for the person in charge to have appropriate oversight of the identified risks in the centre. Specific risks that may impact individuals, such as falls risks, had also been assessed to inform care practices.

Judgment: Compliant

Regulation 28: Fire precautions

There were a number of suitable fire safety management systems in place, including detection and alert systems, emergency lighting and firefighting equipment, each of which was regularly serviced.

However, the majority of fire containment doors did not have self-closing devices fitted as required. While this was self-identified by the provider, the issue was ongoing for an extended time frame and there was no set dates as to when they would be sourced and installed.

Two fire containment doors had a noticeable gap which would allow for the spread of smoke and fire in the event of a fire. In addition, one fire containment door that did have a self-closing device would not close fully by itself.

It was not evident if all of the recommendations from the servicing of the alarm and emergency lighting in November 2023 were completed. The inspector observed that one action was completed which related to an emergency light and it was installed externally to the rear of one premises. However, the rest remained outstanding to the best of the person in charge's knowledge. For example, one outstanding action was not all emergency lighting passed a particular service test completed during the service. Emergency lighting was recommended by the professional for outside the front of the premises to guide residents and staff to safety during evacuation during hours of darkness.

There was evidence of periodic fire evacuation drills taking place and up-to-date personal emergency evacuation drills (PEEPs) in place. However, no scenarios were used during those drills which would encourage different doors to be used during

the practice. This would support residents to become familiar with using alternative doors in the case of an emergency. There was no drill completed with minimum staffing levels and maximum resident numbers by the time of this inspection. The person in charge communicated that there already was a plan in place to complete a drill with minimum staffing levels the week after the inspection.

In addition, the fire evacuation plan for the centre was a generic evacuation plan and not specific for the needs of the residents. It did not adequately guide staff as it to how to support the current residents to safety. For example, it did not state the order in which residents were to be evacuated or where to request additional staff help from in order to use the ski-sled.

Furthermore, the inspector observed from a review of documentation that staff were completing their daily fire safety checks. However, it was not evident if staff were completing their weekly safety checks as they were left blank from 2023 to date.

The inspector also raised a query with the provider as to the coverage of the fire alarm that was in the both premises to assure that it provided adequate coverage for the centre. With regard to one premises it was not clear from information provided as to what level of cover and type the alarm was as the inspector saw conflicting information recorded in documentation. The provider submitted written assurances from their competent fire person what type of alarm system was in place and that the alarm type was suitable for the premises.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Prescribed medicines were dispensed by a local pharmacy, and found to be appropriately stored. There were periodic medication audits in place in order to provide appropriate oversight over medication management. In addition, an assessment of capacity was completed with the residents in relation to self-administration of medication.

However, the inspector was not assured that there was an appropriate systems in place for the disposal of medication when no longer required. For example, the inspector observed medication in the cabinet from approximately one year ago that was supposed to have been returned to the pharmacy for a resident that no longer lived in the centre.

Furthermore, Two residents' medication prescribing documents for the administration of in case needed epilepsy rescue medication was signed by their GP. However, they did not specify after what time frame the residents should receive the rescue medication and no max dosage was specified. While the epilepsy protocol did specify this information it was not clear under whose direction the guidelines

came from.

A staff member spoken with was not clear as to when the medication was to be administered. Notwithstanding this, they did assure the inspector that they knew where to find the protocol. They communicated that it was always brought out with the resident and that they would always read it prior to administering the medication.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There were different assessments of need in place for each resident, which identified their health care, personal and social care needs. In addition, there were personal plans in place for identified needs. For example, from a sample of residents' files they had hospital passport documents to guide hospital staff as to how best to support them should they need to attend hospital. Some residents had eating, drinking and swallowing plans. A staff member spoken with was familiar as to the support residents required around their food and drink.

In addition, each resident had identified goals that they were being supported to work towards. For example, one resident wished to go on holidays to Lourdes with their family and to rebuild a friendship with an old friend. Another resident wanted to make their own Christmas cards to send to people and visit a particular harbour in Dublin.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had completed a restrictive practice self-assessed questionnaire. The inspector reviewed this document and found that the practices outlined within the document were consistent with what was observed during the inspection.

The person in charge was found to be promoting a restraint free environment. While there were minimal restrictive practices used within the centre, for example a lap belt used on a wheelchair, they were assessed as being required for residents' safety and subject to review.

Where residents presented with behaviour that may cause distress to themselves or others on occasion, the person in charge had arrangements in place to ensure these residents were supported. For example, residents had a document called ' a wheel of optimal living' which guided staff as to how best to support them based on known

information. If required, residents had access to a behaviour therapist.

Furthermore, all staff had received training in positive behaviour supports that included de-escalation techniques.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents. For example, staff were trained in safeguarding. Staff spoken with were clear on what to do in the event of a concern. In addition, there were intimate care plans to guide staff as to how best to support residents.

Any potential safeguarding risk was reviewed, reported to relevant agencies and where necessary, a safeguarding plan was developed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for DC2 OSV-0002934

Inspection ID: MON-0034780

Date of inspection: 22/03/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Person in charge will review all social activities and ensure documentation of same is always completed and up to date. Person in charge will ensure that all activities are in line with will and preference of residence and documented response to activities from resident is also complete. Due for completion 07.05.2024 Person in charge and PPIM will review resources in order to promote social activities. Due for completion 05.06.2024. Roll out of medication and bucccolam training for all grades of staff. All grades of staff in DC 2 will be enrolled on this training. Roll out to commence 21.05.2024 Person in charge to review all HR files in conjunction with HR and ensure that all Gap's of employment and references are updated. Completed 05.04.2024	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Person in charge will ensure that all staff training is updated on training matrix. Training matrix identifies when training is required to ensure a timely booking of same. When rostering is being planned, the person in charge will ensure that the matrix is consulted in order to allow for timely and achievable booking of mandatory training. Completed 23.04.2024 Person in charge will ensure that all staff members in DC 2 have completed training in cardiac first responders.	

Completed 26/03/24

Person in charge will ensure that all staff in DC 2 have completed Ski sled training for evacuation.
Due for completion: 03.05.2024

The person in charge will ensure that all mandatory training will be completed in a timely manner. The person in charge has booked all mandatory training that will be required this year to ensure that no training expires.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Provider will complete roster review to maximize resource usage, in order to identify protected time for Person in charge to ensure governance and management role is carried out in line with regulation.
Due for completion: 24.06.2024

Newly developed annual audit schedule has been implemented to DC 2. This will allow for increased oversight of all aspect of governance. All actions from audits will be input to QEP to evidence actions required and completed.
Completed 23.04.2024

PPIM and PIC will ensure that all staff in DC 2 will receive supervision in line with current policy throughout the year.
Ongoing throughout the year.

Provider will review staff supervision policy with Department lead of HR.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All fire doors with the DC will have fire door closers installed by the below date.
Due for completion 11.06.24

Provider to develop business plan to be submitted to CH07 in relation to funding to address all outstanding fire issues relating to DC 2.
Due for completion 11.06.24

Person in charge shall ensure that gap in fore door that resulted in inefficiency of same will be addressed by maintenance department. Self-closing device on fire door which had malfunctioned, to be repaired.
Completed 10.04.2024.

Person in charge to ensure that all recommendation from emergency lighting report to be implemented.
Due for completion 26.04.2024.

Person in charge will link with health and safety officer in order to complete scenario-based evacuation fire drills. Person in charge will simulate least resourced times for these fire drills.
Due for completion 10.10.2024.

Peron in charge to review and update all fire plans to include PEEPS. This update will include the order of residents for fire evacuation.
Completed 29.03.2024

Peron in charge will ensure that weekly fire safety checks will be completed and documented. This will be an ongoing action.
Commenced 25.03.2024.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Person in charge shall ensure that there is a protocol in place for the return of out of use medications in a timely manner. Newly implemented schedule of audit shall increase medication management review.
Due for completion 23.04.2024.

Person in charge shall ensure a review of Kardex to identify max does of PRN medications, this will be done in consultation with pharmacy and GP. PRN protocols will be signed by clinical prescriber.
Due for completion 16.05.2024.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	05/06/2024
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	05/04/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including	Substantially Compliant	Yellow	24/09/2024

	refresher training, as part of a continuous professional development programme.			
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	23/04/2024
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	24/06/2024
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	11/06/2024
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape,	Substantially Compliant	Yellow	26/04/2024

	including emergency lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	11/06/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	10/05/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	16/05/2024
Regulation	The person in	Substantially	Yellow	16/05/2024

29(4)(c)	charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Compliant		