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:	Ladywell Lodge
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	07 December 2022
Centre ID:	OSV-0003025
Fieldwork ID:	MON-0038642

About the designated centre

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

Ladywell Lodge is a centre situated on a campus based setting in Co. Louth. It provides 24hr residential care to up to eight adult male and female adults some of whom have complex medical needs. The centre is divided into two separate units which are joined by a communal reception area. Each unit comprises of a large dining/sitting room, additional small communal rooms, adequate bathing facilities, laundry facilities and an office. Residents have their own bedrooms. There is a large kitchen shared by both units where residents can prepare small meals and bake. Meals are provided from a centralised kitchen on the campus. Both units have access to a shared garden area where furniture is provided for residents use. The centre is nurse-led meaning that a nurse is on duty 24 hours a day. Health care assistants also play a pivotal role in providing care to residents. The person in charge is responsible for two other designated centres under this provider. They are supported in their role by a clinic nurse manager in order to ensure effective oversight of this centre. Residents are supported to access meaningful day activities by the staff in the centre and have access to a "hub" on the grounds of the campus where they attend some activities. A bus is available in the centre so as residents can access community facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 7 December 2022	10:20hrs to 16:30hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

This inspection was initially an unannounced inspection to ensure that infection prevention and control measures were appropriate in the centre. However, as the inspection progressed the reason for the inspection was changed to a risk inspection. This was because the inspector identified significant concerns with the governance and management of the centre which were impacting on the quality and safety of care provided to residents.

On arrival to the centre, the inspector found that one staff nurse and five agency staff were rostered to work that day due to planned and unplanned leave. The house hold staff who was responsible for implementing increased cleaning of the centre was also on planned leave, the person in charge, clinic nurse manager and the person participating in the management of the centre were also on planned leave that day. This meant that the staff nurse was responsible to oversee the care and support of all residents, while also supervising and supporting five agency staff (one of whom had only starting working in the centre on the day of the inspection).

The centre is located on a large campus based setting and is made up of two large units which are divided by a central kitchen, offices and reception area. On the day of the inspection the staff nurse was responsible for supervising the care and support of all residents in the centre. On review of some of the resident's plans, the inspector was not assured that this arrangement provided a safe quality service to the residents. For example; one resident was observed asking staff on a number of occasions to go for a coffee. However, the only driver on duty was the nurse who could not leave the centre as they were managing the unit on the day of the inspection.

The inspector reviewed residents care plans and found that, residents had limited access to meaningful activities including the ability to leave the campus. Most of the activities either included a walk on the grounds of the campus or activities in the unit which were also limited. There was also limited information available about some goals that residents had planned. For example; one resident had planned to go to the national ploughing championships during the year, it was not clear whether this had occurred and when the inspector reviewed the resident's daily notes there was no record of them attending this event.

The centre was generally clean, with the exception of the windows in all of the rooms which were covered in a film of dust and the paint was peeling off the windows. This had been identified at the last inspection of the centre in February 2022 and had not been rectified. Audits had also been conducted on infection prevention and control in the centre in November 2022. These audits highlighted some actions that had been ongoing in the centre since the last audit which had also not been addressed. For example; an audit conducted in 2021 highlighted that a kitchen press needed to be repaired and this had not been done.

The staff were observed treating the residents with dignity and respect, the residents were well dressed and it appeared that their basic needs were being attended to on the day of the inspection. Staff were observed bringing residents out for short walks and were engaged in some other activities in the centre. However, on review of the residents support plans, the inspector was not satisfied that the staff in the centre, had all of the necessary skills and knowledge to support the residents who had complex medical needs and social and emotional needs.

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

Overall the inspector found that the governance and management arrangements in place on the day of the inspection were not adequate and did not provide sufficient oversight of the quality and safety of care. The staffing levels and skill mix in the centre did not adequately assure that staff had the necessary skills, knowledge to support the residents with all of their needs. Significant failings were also identified under heath care, the premises, risk management and general welfare and development of residents. These findings had the potential to significantly impact on the safety and quality of care provided to the residents living in this centre and warranted a full review. In addition, the provider did not have adequate contingencies in place should there be a shortfall of staff in the centre again.

Such were the concerns, the registered provider was issued an urgent action plan the day after the inspection requesting them to submit assurances under a number of regulations within a specific time frame. In addition, the registered provider was requested to attend a meeting after the inspection with the Health Information and Quality Authority to discuss the findings of this inspection.

On the day of the inspection the staffing arrangements in the centre did not assure consistency of care to the residents. As stated there was a nurse on duty who knew the residents well, however, as the centre is divided into two units, agency staff were overseeing the care and support in the other area. The inspector found that this arrangement was not sufficient given that one of the residents recently admitted to the centre had been admitted specifically because they required nursing support. All of the managers who were involved in managing the centre were on leave on the day of the inspection (two attended the centre later to facilitate the inspection).This meant that one nurse was left to supervise, support and manage staff while also being responsible for the administration of medication, peg feeds and any other nursing supports that may arise.

The inspector found that the issues in relation to staff shortages and the increased need for agency staff had been reported to senior managers on the 28 November 2022 and up to the time of the inspection the person in charge had received no

response in relation to how this should be managed, risk assessed or to review contingency measures required in the centre.

A review of a sample of rosters also found that, there were times over the last two weeks where insufficient staff were on duty some days. For example; on the 29 November 2022 only four staff worked. The inspector was therefore not assured that the contingencies in place to manage a shortfall of staff in the centre was adequate; particularly given the medical needs of some of the residents in the centre.

The governance and management arrangements were also not adequate as there was limited oversight arrangements in place. At the time of the inspection the person in charge had been appointed to the centre in October 2022. As they are responsible for two other centres a clinic nurse manager was also employed to support them and assist with the oversight arrangements in the centre. At the time of this inspection, no meeting had been held to discuss the roles and responsibilities each person would take on. For example; at the time of the inspection not all staff had supervision completed and the last team meeting had been held in September 2022.

The person in charge reported to a person participating in the management (PPIM) of the centre who is the director of care and support. While the person in charge stated that they met with the PPIM to discuss actions from audits that had been outstanding since 2021, there were no minutes of these meetings recorded. It was therefore not clear who had been assigned responsibility for these actions to ensure they were conducted in a timely manner. The absence of those minutes did not assure transparency and accountability of services delivered or that concerns raised by the person in charge were being addressed.

While audits were being conducted in the centre, a large number of the actions had not been completed. For example; the transport used in the centre had been repaired on 24 October 2022 and some of the repairs following this had not been completed. A quality enhancement plan made available to the inspector showed that actions in relation to fire safety had not been addressed in a timely manner. An infection prevention and control audit conducted on 01 November 2022 indicated that blinds needed to be cleaned, a store room was cluttered, flooring in the bathroom was worn, and one issue had dated back to June 2021 where a kitchen press had not been repaired.

Refresher training had been highlighted on a quality enhancement plan for the centre as far back as the last inspection in February 2022. The training records made available to the inspector indicated that some staff were due to complete refresher training, however, some of the refresher training had not been completed in a timely manner. For example; two staff were due to complete refresher training in manual handling, one since 2020 and the other since 2021. This training had not been completed. In addition, on the day of the inspection it was not clear whether all staff had completed a specific first aid technique to support one resident.

Regulation 15: Staffing

On the day of the inspection the staffing arrangements in the centre did not assure consistency of care to the residents. As stated, one nurse was on duty who knew the residents well, however, as the centre is divided into two units, agency staff were overseeing the care and support in the other areas. The inspector found that this arrangement was not sufficient, given that one of the residents recently admitted to the centre had been admitted as they required nursing support on a full time basis. This resident was residing in the unit where all staff employed on the day of the inspection were agency care staff.

All of the managers who were involved in managing the centre were on leave on the day of the inspection (two attended the centre later to facilitate the inspection).This meant that one nurse was left to supervise, support and manage staff while also being responsible for administration of medication, peg feeds and any other nursing supports that may arise.

A review of sample of rosters also found that there were times over the last two weeks where insufficient staff were on duty some days. For example; on the 29 November 2022 only four staff worked. The inspector was therefore not assured that the contingencies in place to manage a shortfall of staff in the centre was adequate; particularly given the medical needs of some of the residents in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The training records made available to the inspector indicated that some staff were due to complete refresher training, however, some of the refresher training had not been completed in a timely manner.

In addition, on the day of the inspection it was not clear whether all staff had completed a specific first aid technique for one resident.

At the time of the inspection, supervision was not completed for all staff in line with the providers own policies and procedures.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangements were not adequate as there was limited oversight arrangements in place. At the time of the inspection the person in charge had been appointed to the centre in 2022. As they were responsible for two other centres a clinic nurse manager was also employed to support them and assist with the oversight arrangements in the centre. At the time of this inspection, no meeting had been held to discuss the roles and responsibilities each person would take on. For example; at the time of the inspection not all staff had supervision completed and the last team meeting had been held in September 2022.

The person in charge reported to a person participating in the management (PPIM) of the centre who is the director of care and support. While the person in charge stated that they met with the PPIM to discuss actions from audits that had been outstanding since 2021, there were no minutes of these meetings recorded. It was therefore not clear who had been assigned responsibility for these actions to ensure they were conducted in a timely manner. The absence of those minutes did not assure transparency and accountability for services provided.

While audits were being conducted in the centre, a large number of actions from these had either not been completed or were not completed in a timely manner. For example; the transport used in the centre had been repaired on 24 October 2022 and some of the repairs following this had not been completed. A quality enhancement plan made available to the inspector showed that actions in relation to fire safety had not been addressed in a timely manner. An IPC audit conducted on 01 November 2022 indicated that blinds needed to be cleaned, a store room was cluttered, flooring in the bathroom was worn, some of these issues had dated back to June 2021.

At the time of the inspection the centre was not adequately resourced, the bus in the centre was only suitable to accommodate one wheelchair user. There was insufficient staff rostered on duty some days and there were no contingencies in place for the management of the centre when staff were on planned or unplanned leave.

Staff meetings were not a regular occurrence in the centre. The last staff meeting had occurred in the centre in September 2022. There were no minutes of meetings recorded with the person in charge and the director of care and support to ensure that the person in charge was able to raise concerns about the quality and safety of care being provided and to assure that appropriate measures were taken to address those concerns.

Judgment: Not compliant

Quality and safety

At the time of this inspection residents were not being supported to have a meaningful life in the centre. The inspector found that health care needs required

reviewed and that access to allied health professionals was not accessible to one resident in relation to their mental health. In addition, risk management processes were not adequate and had not be reviewed to reflect the changes in relation to the staffing arrangements in the centre.

The centre was for the most part clean, although as mentioned some of actions from the last inspection had not been completed. In addition audits had highlighted issues with the premises which were not being addressed in a timely manner.

The provider had developed a contingency plan to prevent/manage an outbreak of COVID-19 in the centre. This included providing personal protective equipment (PPE), ensuring that staff had been provided with training in infection prevention control and donning and doffing of PPE. Enhanced cleaning schedules was one contingency provided for, however, at the time of the inspection it was not clear how this was to be managed as the household staff was on leave and no other contingency was put in place.

Residents had access to a range of allied health care professionals. This included General practitioner (GP) services, physiotherapist, occupational therapist and a dentist and optician. However, recommendations made by two allied health professionals were not being implemented for one resident on a daily basis. In addition, there was conflicting information on one residents care plan in relation to a recurring health care concern which staff could not fully explain.

The inspector also reviewed one residents records in relation to their mental health and found that the resident had not been reviewed by a psychiatrist since January 2022 despite changes in their presentation and increases in the administration of as required medicines. While staff in the centre had arranged appointments they had been cancelled.

The same resident had a positive behaviour support plan in place to guide staff practice on how best to support the resident this had not been reviewed since August 2021 despite changes in some of the strategies outlined in the residents behaviour support plan.

End of life plans were in place for some residents which had been reviewed by a GP, however, this was not in line with the policy of the organisation which outlined that this review should be multi-disciplinary in nature. The inspector was not assured therefore that the review fully considered or respected the autonomy, rights and wishes of the resident.

The registered provider had systems in place to manage risk, however, given the staffing arrangements in the centre, the inspector was not satisfied that risk assessments had been reviewed. For example; one risk assessment stated that a resident needed to have staff trained in a specific technique in an emergency due to a known health care issue and it was unclear whether this training had been completed. Another residents risk assessment required them to have staff trained in a specific behaviour support technique however, it was also not clear whether all staff had this completed including refresher training.

Regulation 13: General welfare and development

The registered provider did not have arrangements in place at the time of the inspection to ensure that residents had access to meaningful activities or opportunities to participate in activities that they were interested in or liked.

There was also limited opportunities for residents to build links with the wider community as most of the activities that residents engaged in included walks on the campus or activities in the centre some of which were recorded as having a lie on, watching television, listening to music, watching mass on the television or getting a takeaway.

Judgment: Not compliant

Regulation 17: Premises

At the last inspection it had been observed that most of the windows in the residents' bedrooms needed to be cleaned, repainted and repaired. This had not been completed despite the provider submitting written assurances in their compliance plan that it had been completed.

Some storage areas in the centre were cluttered and although identified as an issue in the providers own audits they had not been addressed.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had systems in place to mange risk, however, given the staffing arrangements in the centre the inspector was not satisfied that risk assessments had been reviewed.

For example; one residents risk assessment in relation to a health care need, stated that the resident should be supported by staff who had been shown a specific first aid technique prior to working in the centre. The clinic nurse manager and staff nurse could not verify this and it was not outlined in any of the induction forms completed by agency staff. It was also not clearly outlined in the risk assessment how the resident should be supervised in the centre to mitigate the health care risk.

Another residents risk assessment outlined that staff should have training in positive

behaviour techniques.

At the time of the inspection, the vehicle used to transport had some outstanding work to be completed following a service. This included fixing some lights to the back of the vehicle.

Judgment: Not compliant

Regulation 27: Protection against infection

While the centre appeared to be clean on the day of the inspection, there was no contingencies in place to ensure that enhanced cleaning schedules could be implemented due as the household staff was on planned leave. The inspector was informed that in this instance staff rostered on duty were in charge of ensuring this, however when the inspector spoke to some of the staff they were not aware that washing floors was part of their duties and another staff stated that they would try their best to get the cleaning schedules completed.

Judgment: Substantially compliant

Regulation 6: Health care

Recommendations made by two allied health professionals were not being implemented for one resident on a daily basis. In addition, there was conflicting information on one residents care plan in relation to, a recurring health care concern which staff could not fully explain in relation to pain management for this resident.

The inspector also reviewed one residents records in relation to their mental health and found that the resident had not been reviewed by a psychiatrist since January 2022 despite changes in their presentation and increases in the administration of as required medicines. While staff in the centre had arranged appointments they had been cancelled.

The same resident had a positive behaviour support plan in place to guide staff practice on how best to support the resident this had not been reviewed since August 2021 despite changes in some of the strategies outlined in the residents behaviour support plan.

End of life plans were in place for some residents which had been reviewed by a general practitioner, however this was not in line with the policy of the organisation which outlined that this review should be multi-disciplinary in nature. The inspector was not assured therefore that the review fully considered or respected the autonomy, rights and wishes of the resident.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Ladywell Lodge OSV-0003025

Inspection ID: MON-0038642

Date of inspection: 07/12/2022

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: 1. CNM1 rostered 37.5 hours supernumerary for Ladywell Lodge exclusively 12/12/22 until such time as the centre becomes compliant in all areas. 2. PIC and House Manager are working opposite each other with identified overlap time to meet and feedback on actions & progress planning. 3. 2 permanent staff nurses allocated to House 1 permanent staff nurse to commence 2nd week Feb 2023 1 permanent HCA allocated to house 2 On-call relief HCAs allocated to House 4. Two Staff nurses rostered daily – one allocated to each side of the Designated centre. 5. Rosters will be planned Monthly in advance, to assure adequate skills mix across the week from our core staff. 6. Nursing Administration will be advised in advance where members of the core staff completement leave the service or are absent on extended leave.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

1. All staff refresher training will be completed by end Feb
2. All staff currently on the roster have been trained in the Jaw-Thrust technique. The Jaw-Thrust technique training has been added to the Induction form to ensure that all new staff receive the training of the technique.

3. A supervision and PDR schedule is in place for 2023 which complies with the orders policy on supervision

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. PIC and CNM1 met on 05/01/2023 to discuss roles and to clarify processes, roles and responsibilities for each party

2. A schedule has been developed for Supervision of all staff

3. A full team meeting was held in Ladywell on 21/12/2022. Monthly Team Meeting are scheduled for 2023.

4. Meetings between PPIM and the PIC/CNM1 being held bi-weekly to verify progress on actions and meetings are minutes taken

5. All actions from audits are added to the QEP. The QEP is being reviewed weekly by the PPIM and PIC/CNM

6. All IPPs have been audited and arising actions required are highlighted and completion dates assigned.

7. Residents DNRs were reviewed with the MDT on 13th December 2022

8. The vehicle for the DC has been replaced and an additional vehicle will be allocated to the DC on 23/01/23

9. Developed a planned monthly roster that ensure adequate skills mix across the week

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development: 1. The vehicle for the DC has been replaced and an additional vehicle will be allocated to the DC on 23/01/23 2. All IPPs have been audited regarding social goals and meaningful day activities. Each individual will be supported in line with their assessed need. 3. Residents will be informed at resident's weekly meetings of the schedule of available activities within their local activity. Residents will be encouraged to develop and maintain links within their local community in line with their assessed need and choice. 4. Community PIC is providing training for staff on setting meaningful goals for residents in Ladywell Lodge 5. Assistant Director of Nursing is conducting training for staff Thursday 19th on Person Centered Planning and structuring a meaningful day with all staff	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. All internal windows & frames will be repainted & sealed. 15/02/2023 2. Storage areas around the DC have been decluttered	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 1. All staff currently on the roster have been trained in the Jaw-Thrust technique. The Jaw-Thrust technique training has been added to the Induction to ensure that all new staff receive the training 2. All Core staff have been trained in Positive Behaviour Support Techniques 3. All residents risk assessments have been reviewed and updated as part of the IPP audit	

4. The vehicle for the DC has been replaced and an additional vehicle will be allocated to the DC on 23/01/23

5. Planned monthly rosters are being completed to assure adequate and even skills mix across the week to ensure permanent staff with positive behavior support training are on duty daily.

6. All core staff of the designated Centre are aware of their daily cleaning duties as per our community model. All agency staff employed within the DC will be informed of their cleaning duties as part of their induction.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. All core staff of the designated Centre are aware of their daily cleaning duties as per our community model. All agency staff employed within the DC will be informed of their cleaning duties as part of their induction.

2. Cleaning schedule: cleaning will be emphasized during the induction of all new staff and new agency staff to include staff roll with regards to cleaning and completion of cleaning schedule.

3. Planned monthly rosters are being completed to assure adequate and even skills mix across the week to ensure that there is an improved balance of permanent staff and less dependency on agency staff.

4. Deep clean commencing within the DC & rescheduled every 6 months excluding specific events where it may be required more frequently. 12/01/23

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. A specific room has been adapted and cushioned to provide a safe space for a resident to follow recommendations from allied Health professionals.

2. The CNS in Health Promotion & Intervention is assisting staff with revising health care

plans.

3. Pain management plan for the resident has been reviewed by his GP

4. Resident's behaviour support plan was reviewed 03/01/2023

5. Psychiatric reviews have taken place on December 14th and review dates have been scheduled for follow up.

6. Two residents DNRs were reviewed with the MDT on 13th December 2022

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)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	22/01/2023
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	22/01/2023
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Not Compliant	Orange	22/01/2023

	their wishes.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Red	09/12/2022
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.	Not Compliant	Orange	28/02/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/01/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	15/02/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	12/01/2023
Regulation	The registered	Not Compliant	Orange	09/12/2022

23(1)(b)	provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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.	Not Compliant	Red	09/12/2022
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	21/12/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment,	Not Compliant	Red	09/12/2022

	management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	23/01/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	22/01/2023
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	03/01/2023
Regulation 06(3)	The person in	Not Compliant	Orange	13/12/2022

	charge shall ensure that residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.			