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:	Glen 3
Name of provider:	Avista CLG
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	10 March 2023
Centre ID:	OSV-0003727
Fieldwork ID:	MON-0036236

About the designated centre

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

The designated centre consists of three bungalows located in a campus setting and provides a residential service for up to 16 residents who have an intellectual disability and require moderate to high support interventions. The centre is located in a suburb of Co. Dublin with access to a variety of local amenities. Residents are supported 24 hours a day by a team comprising of a person in charge, clinical nurse manager, staff nurses, social care workers, healthcare assistants and household staff. Residents are supported to engage in a range of activities which were meaningful to them both in the community and on the campus where the centre was located. The houses in the centre are purpose built and there is a living room, shared dining and kitchen area, a smaller sitting room, two bathrooms, an office and staff room, laundry room and attic space for storage. Each resident had their own bedroom which was decorated in line with their individual preferences and needs. One resident has their own apartment, attached to one of the bungalows by an adjoining door. Each house has a shared garden and patio area which leads on to the main campus gardens.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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 10 March 2023	09:00hrs to 18:10hrs	Erin Clarke	Lead
Friday 10 March 2023	09:00hrs to 18:10hrs	Marie Byrne	Support

What residents told us and what inspectors observed

The purpose of this unannounced risk-based inspection was to assess the provider's progress with their submitted improvement plan following the previous inspection of the centre in December 2021. To evaluate the impacts and outcomes for residents, the two inspectors of social services focused the inspection on key quality and safety regulations. Overall, it was found that a number of actions proposed by the provider to reach compliance with a number of regulations, such as residents' personal plans and goals, staffing arrangements and compatibility assessments, had yet to be successful or remained outstanding. The inspectors found good practice in the reduction of restrictive practices but found further improvement was required in the admission process of residents into the centre, personal plans, continuity of staff and the monitoring systems of care and support being provided to residents.

The inspectors had the opportunity to meet and spend time with 15 of the 16 residents that lived in the designated centre and to visit all three bungalows. They also met with the person in charge, the person participating in management and the service manager during the course of the inspection day. They showed knowledge and oversight arrangements were in place in the designated centre and were familiar with both the support and care needs of the residents. As well as observations of residents' daily lives, interactions of staff with residents and discussions with key personnel, the inspectors completed a documentation review in relation to the care and support provided to residents.

This designated centre consists of three large bungalows, which is registered for 16 residents. The designated centre is located on a congregated mixed-use campus setting with six other bungalows with an overall capacity for 52 residents. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner. As per the centre's statement of purpose, the specific care and support needs this designated centre is intended to meet are residents with a moderate to severe intellectual disability. In addition, each bungalow is designed to support specific needs.

Bungalow one accommodates five residents with the following needs; autistic spectrum disorder, complex mental health needs and those who may require positive behaviour support with behaviours of concern. This bungalow has a self-contained apartment that allows one resident to have their living arrangements set out in a specific manner that best suits their specific needs. The second bungalow supports six residents who may require support with a mental health diagnosis or behaviours of concern that require positive behaviour support. Residents may also need support with complex medical and physical needs such as epilepsy and mobility issues. As per the centre's statement of purpose, this house requires a high ratio of nursing staff. Five residents live in the third bungalow who may require support due to complex medical, physical or sensory needs. One resident in this house has additional living space and staff in line with their assessed needs.

The inspectors reviewed the processes in place for residents moving into the centre and the documentation of residents' assessments. The inspectors found that improvements were required in the admission processes to ensure that the admissions procedure and statement of purpose were adhered to, enhancing residents' rights, safety and the management of risks in the centre.

The inspectors were made aware that while there were a sufficient number of staff in each bungalow, there was not a consistent staff team in place at all times. The person in charge was assisting staff in one bungalow due to difficulties in achieving the skill mix of staff required in that bungalow. On the day of the inspection, there was an agency staff nurse, two student nurses and one regular care staff on duty. From a review of the roster, it was seen that there was a reliance on the use of relief and agency staff to fulfil several shifts due to several staffing vacancies. As seen in previous inspections, difficulty in recruiting the centre's required staffing complement had been a long-standing issue within the centre. The service manager informed inspectors that a staffing review was underway to ensure that the whole-time equivalent staff numbers were sufficient to meet residents' assessed needs.

Inspectors spoke with a number of staff about the impact of completing human rights training. One staff spoke about how they felt they were always very person-centred in terms of their approach to supporting residents; however, they felt that the training made them think more about how they could further support residents to make choices and decisions in their day-to-day lives. They also described how it had encouraged them to work with residents to become more independent in their day-to-day lives if they wished to, such as completing their laundry, packing the dishwasher, and getting themselves drinks and snacks. Another staff spoke about how they had noticed that staff were more focused on residents' rights following the training. For example, a resident had chosen to buy themselves furniture, and the company had sent the receipt to the provider, and staff had contacted them to send the receipt to the person as this was important to them.

On arrival to one of the bungalows inspectors were greeted by one resident as they left the house to go for breakfast in the restaurant on the campus with day service staff. On return, they spoke with the inspector and staff about how much they had enjoyed their breakfast. One resident had gone bowling the evening before the inspection. In each of the bungalows visited, residents appeared comfortable and content in their homes. Residents were observed to move freely around their homes and to spend time in their preferred spaces. One part of the bungalow was sparsely decorated which was consistent with the residents' preferences that lived in part of the centre.

Staff were observed to be familiar with residents' care and support needs, and those who spoke with inspectors were very familiar with residents' preferences and motivated to ensure they were happy and safe in their homes. Warm, kind, and caring interactions were observed between residents and staff. Staff spoke with inspectors about how residents liked to spend their time. Some staff referred to difficulties supporting residents to enjoy activities in their local community due to staff shortages, at times, particularly over the last few weeks. The provider recognised this in their own audits and reviews, and the agenda for the upcoming

staff meeting included discussions around activities, care plans and residents' goals.

There was a picture of the human rights officer in the organisation available to residents in the houses. They had visited the centre and provided training and supports for residents and staff. For example, they completed mealtime audits and made some recommendations to further improve the experience for residents. There was also information available on human rights and the availability of independent advocacy services and the confidential recipient. In addition, the daily safety pause completed in the centre regularly included human rights. A number of residents in the centre were members of the advocacy group for the campus. They had a folder with the minutes of these meetings and actions that had been brought about as a result of their meetings. There was an easy-to-read folder available for residents, and it included information on topics such as my money, my rights, the FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy), infection prevention and control, visitors, understanding and reporting abuse, grief and loss, reducing falls risks and complaints.

An inspector observed a mealtime experience for residents in one of the houses. There was a quiet and relaxed atmosphere in the dining room. The table was set with condiments, and there were three choices of drinks available. A picture menu was available on the table, and staff were observed supporting residents in choosing what they wanted for their meals. For those residents who required staff support, they were provided with support by staff in a kind and sensitive manner. For example, one staff was sitting at the table chatting with residents while they enjoyed their meal and supported a number of residents during their meal with drinks and condiments. Another staff sat facing a resident and fed them their meal at a pace that appeared to suit them. They spoke with the resident about their plans for the day and their meal while supporting them. Staff were observed to listen to residents' requests for extra helpings of food and to respond in a kind and caring manner.

In one of the bungalows, an inspector observed an interaction where one peer was negatively impacted by something that their peer said to them. Staff responded appropriately and supported both residents to ensure they were happy and comfortable. After supporting both residents, they reported this interaction in line with the provider's and national policy.

Although the general care and support of residents were observed to be good on the day of this inspection, there was non-compliance with a number of the regulations. This meant that residents were not always being afforded with safe and person-centred services that met their assessed needs. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service.

Capacity and capability

As referenced in the opening section of this report, the provider had failed to implement all actions from previous inspections of the centre and the submitted representation plan to the Chief Inspector of Social Services. Based on this inspection, the inspectors found that the governance and management systems in place had not ensured that the services provided within the centre were in full compliance with the regulations.

Previous inspections of this designated centre carried out in November 2020 and August 2021 found significant levels of non-compliance in areas such as governance, complaints, staffing, restrictive practices, safeguarding and the promotion of residents' rights. As the provider had not demonstrated that they could achieve a satisfactory level of compliance, the Chief Inspector proposed to refuse the provider's application to renew the centre's registration. In response, the provider submitted a detailed response outlining the actions they were going to take to bring the centre into the compliance. Part of this response was the establishment of a governance and oversight committee comprising of members of the executive team and management team within the campus. The aim of this group was to address and oversee the implementation of the plan to address areas of non-compliance and to ensure the delivery of person-centred support. A follow-up inspection in December 2021 found some areas of improvement, and the centre had its registration renewed until December 2024.

The purpose of the current inspection was to assess if the provider had completed its stated actions as submitted following the previous inspection and what impact these had on the compliance levels for this centre and quality of life for residents. The overall findings of this inspection highlighted that further improvement was required regarding the monitoring systems in place for the centre. While it was acknowledged by management that progress had been delayed in completing some of the proposed actions and plans to strengthen the governance of the centre in the coming months were discussed, inspectors nevertheless identified recurring breaches of regulations. The compliance plan submitted following the December 2021 inspection gave a timeline of six months to bring the centre back into compliance. However, the inspectors found many of these actions remained outstanding eight months after this due date.

Regulations require all registered providers to carry out an annual review of the quality and safety of care and support of each designated centre. The inspectors reviewed the annual review for 2022, which was completed in January 2023 by the provider's quality and safety officer. Within the report, there were 33 recommendations made by the quality and safety officer in several areas, including staff training, risk management, assessment of need, complaints, supervision and fire safety measures. The quality and safety officer found that while the campus has an oversight committee, progress was slow in addressing issues of concern while examining the centre's governance. The report further identified that while six-month audits had been undertaken, they were not identifying a number of issues. Where actions had been identified and assigned, a number of actions remained outstanding.

Since the last inspection, one resident had transitioned into the centre in November

2022. The resident had transitioned from a respite service within another congregated centre, and the inspectors requested to view the transition plan, admission meetings and the completed assessment of need prior to admission, as required by the regulations. In addition, the inspectors viewed the provider's 'Admission, Discharge and Transition' policy. The current policy was under review, and the new policy was in a draft format and available for inspectors to review. Both policies were reviewed by inspectors. The inspectors noted that the policy in draft format was comprehensive and gave persons in charge additional guidance in the admission processes. The policy referred to the requirements of the regulations in ensuring that residents were provided with a contract of care prior to admission to the centre and an individual needs assessment and preference process. However, from the documentation reviewed and discussions held with management, these requirements had not been completed. Concerns regarding the admission procedures are discussed in more detail under Regulation 24.

The provider had recognised in their annual review that staff supervision was not being completed in line with the provider's policies. The inspectors acknowledge that there was a schedule in place for 2023 and that the sample the supervisions reviewed were detailed in nature and included staff's roles and responsibilities for the quality and safety of care and support they are delivering. In addition, a number of staff told inspectors that they were well supported in their role by the person in charge and the local management team. For the most part, staff were provided with training and refresher training in line with the provider's policies and residents' assessed needs. However, a small number of staff required training or refresher training in areas such as fire safety, manual handling, and hand hygiene.

Regulation 14: Persons in charge

The provider had ensured that a person in charge had been appointed to work full time and they held the necessary skills and qualifications to carry out their role.

A new person in charge had been appointed since the previous inspection. The person in charge commenced their role in January 2022, and their remit was over this designated centre only. They were very familiar with the residents assessed needs and it was evident during the inspection that they had regular contact with all the residents. On the day of the inspection due to staff shortages and unfamiliar staff working in the centre, the person in charge was providing direct support to residents.

Judgment: Compliant

Regulation 15: Staffing

Staffing was identified as an area requiring improvement in five previous inspections of this centre dating back to 2019. It remained a challenge at the time of this inspection. Management advised that recruitment was ongoing and that although staff had been hired, staff resignations and various types of leave meant that it was difficult to maintain the required staffing levels.

Staffing vacancies were evident across all grades in the centre, including nursing staff, social care workers and healthcare assistants. While the provider had ongoing recruitment drives, there was an 8.5 whole-time equivalent (WTE) vacancy. In addition, there were three WTE staff on unplanned leave. This resulted in approximately one-third of the required staffing compliment not being in place.

The inspectors reviewed a sample of rosters. Over a four-week period, there were 129 shifts covered by relief and agency staff across the three houses. Of these, 95 shifts were completed by relief staff and 34 by agency staff. Although it was evident that the provider was attempting to ensure continuity of care and support through the use of regular relief, due to the volume of shifts that needed to be covered, this was not always possible.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff working in the centre had access to appropriate training as part of their continuous professional development, and to support them in delivering good care to residents. The person in charge maintained a register of what training was completed and what was due. However, some improvement was required to ensure staff received the required training and refresher training in areas such as fire safety, manual handing, and hand hygiene.

The provider had identified through its annual review, improvement was required to the frequency of staff supervision in line with policy. The inspectors also identified that the frequency of staff meetings required improvement in order to provide staff with opportunities to discuss aspects of the quality and safety of the care and support provided to residents and ensure consistent practices.

Judgment: Substantially compliant

Regulation 23: Governance and management

Taking into account findings under other regulations during this inspection, the failure to address actions from the previous inspection and the repeated breaches of regulations, the provider's monitoring systems were not ensuring that the service

provided was safe, appropriate to the needs of all residents' needs, consistent and effectively monitored. Where service improvements were identified, these were not always implemented by the provider.

The inspectors found that the provider was not successful in completing the submitted compliance plan in response to the previous inspection's findings from December 2021. On review of the quality improvement tracker, a number of actions were classified as 'late' with 37 actions with due dates from November 2021 to December 2022.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The resident did not have a complete assessment of needs prior to moving into the centre to ensure that the centre would safely and effectively meet the resident's needs. More concernedly, compatibility assessments had not occurred prior to this transition despite the concerns actioned on previous inspections.

Another requirement of this regulation also had not been met. It was not demonstrated that a recently admitted resident had received a contract of care that outlined the services provided in the centre, terms and conditions of their residence and fees payable by them, with the opportunity to agree these terms and conditions with the support of a representative if required.

Judgment: Not compliant

Quality and safety

This section of the report describes the quality and safety of the service for the residents who lived in the designated centre. As discussed in the opening section of the report, the inspectors observed good practice had taken place with improvement in the mealtime experience for residents. The inspectors also found that the healthcare needs of residents were well met, and improvements had been made in the implementation of safeguarding measures. The practices regarding restrictive practices had been strengthened, which had positive outcomes for residents. Staff and residents had support from the Human Rights Officer to review how residents' rights could be further promoted and developed. Overall, the inspectors found that, while the provider was attempting to enhance the quality of care in the designated centre, the long-standing and persistent lack of comprehensive assessment of needs continued to present difficulties in planning for residents' will and preferences.

The previous two inspections identified particular concerns regarding the resident

mix in one bungalow of the designated centre. This contributed to concerns around safeguarding and the centre's ability to meet the assessed needs of all residents living there. In particular, for one resident, it was known that the resident was living in an environment that was not conducive to their wellbeing as they found shared living difficult. While the resident had their own living room, compatibility issues remained.

Inspectors were informed during the last inspection that compatibility assessments and residents' will and preferences assessment would be prioritised for the entire campus in 2022 as part of looking at the decongregation of the campus in line with the National Housing Strategy. The inspectors requested an update on these assessments, but they were still in their infancy and had not led to any transitions for residents. The inspectors were provided with the update that residents were discussed at overall transition meetings, and a strategic lead had been appointed for decongregation from campus settings. For one resident concerned, progress had been made regarding identifying an appropriate living environment. While these were positive steps in addressing residents' will and preferences regarding who they lived with and with how many people they lived with, this action had seen significant delays.

In the provider's representation to the Chief Inspector in October 2021, the provider stated they recognised the importance of the identification of needs and preferences of each resident in ensuring the environment in which they live is appropriate to their needs. To meet that objective, a comprehensive individual needs and preference assessment (IPNA) would be fully completed for all residents in the centre. The provider's response included the involvement of the multi-disciplinary team in the identification of the assessed needs of each individual living in the centre. This included reviewing personal plans inclusive of person-centred plans and the suitability of current accommodation in the designated centre to meet their assessed needs. During the follow-up inspection in December 2021, it was found that while IPNAs were to be completed by the end of 2021, the provider had delayed the deadline due to the amount of work required to complete these assessments. The provider responded through the submitted compliance plan that these would be completed by 30 April 2022.

The inspectors were informed at the start of the inspection that the campus was in the process of implementing a new assessment of need and care plan in the centre. The purpose of this change was to streamline the personal plan process for staff. While the benefits of this change was clearly communicated, it did not align with the provider's transition policy, previous compliance plans or representation and again delayed the completion of the above actions.

When in the bungalows, the inspectors found there was a combination of old and new support plans in place due to the change discussed above. The inspectors found there were sections in a number of residents' assessments and personal plans that were not fully completed, and therefore they were not clear in relation to some of their care and support needs. For example, residents' financial assessments, assessments for mobilising, and women's health sections were either not fully completed or found to contain conflicting information. It was identified in the

provider's six-month audit from January 2023 that some residents had no person-centred planning meeting since 2020. In one house, only one resident had a planning meeting in 2022. While there was some good evidence that residents had been supported to set and achieve meaningful and personal goals, some goals had not been followed through, and these were not documented or updated.

There were a number of restrictive practices in the centre, including swipe access doors, lap belts, locked presses, modified clothing, bed rails and restricted access to kitchens. Some of these restrictions were in place to reduce anxiety related to a non-organised living environment. The inspectors found that since the previous inspection, there was an increased awareness of restrictive practices, oversight, multi-disciplinary review and recording of restrictive practices. A Human Rights Officer supported residents to ensure the restrictions were the least restrictive for the shortest duration. As a result, there was evidence of rights restoration plans in producing incremental changes to reduce these restrictions. The inspectors observed a reduced number of restrictions compared to previous inspections, with residents moving freely around the centre.

Regulation 5: Individual assessment and personal plan

The regulations clearly state that a formal assessment of a resident's social, health, and wellbeing needs to be completed before admission to a centre and at regular intervals after admission. The inspectors found this had not been completed for a new admission to the centre and had not been regularly completed for residents living in the centre. Under Regulation 5, there are specific requirements that must be adhered to in preparing, reviewing and presenting personal plans. The inspectors found gaps in several of the requirements of this regulation and non-adherence to previously submitted compliance plans.

- Not all residents had a current, full and completed assessment of need with multi-disciplinary input.
- The review of the residents' personal plans did not involve assessing the plan's effectiveness and taking into account changes in circumstances and new developments.
- Recommendations leading out from these reviews, including any proposed changes to the plan, the reason for these changes and names of those responsible for pursuing objectives in the plan, were not recorded.
- Personal plans had not been developed with the participation of each resident and or with their representative.

An individual needs and preference assessment was planned for each resident in the designated centre in 2022, as the provider had recognised that some residents' assessments were not reflective of their care and support needs. As part of these assessments, the provider planned to review the compatibility of residents living together and identify residents' wishes and preferences in relation to their

accommodation. These had not been formalised at the time of the inspection.

Judgment: Not compliant

Regulation 6: Health care

Residents were being supported to enjoy the best possible health. Those who required it had access to allied health professionals and were in receipt of support at times of illness. Health action plans and short-term care plans were developed and reviewed as required. Residents were supported to access national screening programmes in line with their age profile and their wishes and preferences.

A list of appointments with relevant professionals was maintained. The inspectors saw that residents accessed consultants, dentists, dietitians and other multi-disciplinary professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Restrictive practise were reviewed regularly to ensure the least restrictive practices were used for the shortest duration. Where restrictions were deemed necessary, there were risk assessments, skills teaching programmes to support residents who were impacted by restrictions, and restraint reduction plans.

Residents who required them had behaviour support plans in place. From a review of a sample of these documents, they were detailed in nature and contained sufficient detail to guide staff practice in supporting residents to manage their behaviour.

Judgment: Compliant

Regulation 8: Protection

Safeguarding concerns were being managed in line with the provider's and national policies and procedures. Safeguarding plans were developed and reviewed as required. The provider was in the process of completing a number of compatibility and individualised needs and preference assessments, and these will be discussed further under Regulation 5.

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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glen 3 OSV-0003727

Inspection ID: MON-0036236

Date of inspection: 10/03/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Service Manager is working with the HR department to fill vacant posts. Interviews have been held 30/03/23, 03/04/23 and 17/04/23. A Recruitment open day will be held in June 2023 for the center. The provider will continue to make efforts to assign regular relief staff to the designated center.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC will continue to up date training records and will liaise with the training department to plan and schedule training as required. All staff currently requiring refresher training will be scheduled to attend training in the second quarter. PIC has a schedule in place for monthly staff meetings for the remainder of the year. PIC will ensure all staff receive supervision by the end of June in line with service policy	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Service Manager has put in a system to notify the authority in the event of actions not been successfully completed within the time-frame given in the submitted compliance plan.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and	

contract for the provision of services:
The service manager has completed a review of the admission to the designated center.

The resident and family representative have been provided with a contract of care – The PIC is awaiting the family representative sign off and return of the contract.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A new assessment of need and care plan is currently being developed for each resident which will ensure each person's health, personal and social care needs are identified with appropriate support plans in place in line with regulatory requirements.

A revised schedule will be completed by the PIC to ensure Individual Preference and Need Assessment are completed for all residents in line with their changing residential requirements as required to support decongregation.

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(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	Orange	31/12/2023
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	30/06/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2023

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.	Not Compliant	Orange	31/12/2023
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	31/12/2023
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	30/06/2023
Regulation 24(3)	The registered provider shall, on admission, agree in writing with	Not Compliant	Orange	31/05/2023

	each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	31/05/2023
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Not Compliant	Orange	31/05/2023
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	31/05/2023

Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/05/2023
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	30/06/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Not Compliant	Orange	30/06/2023

	needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	30/06/2023
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Not Compliant	Orange	30/06/2023
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Not Compliant	Orange	30/06/2023