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:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Dublin 10
Type of inspection:	Announced
Date of inspection:	26 June 2024
Centre ID:	OSV-0003730
Fieldwork ID:	MON-0034649

About the designated centre

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

The centre is based in Dublin and operated by the Health Service Executive. It consists of one building, within a hospital campus. Care and support is provided for up to seven adult residents, both male and female with a physical, sensory or neurological disability. At the time of inspection there was one vacancy in the centre. The building comprised of seven large bedrooms with ensuite facilities. There is also a large sized day room, family room and industrial styled kitchen. Support is provided for residents over a 24 hour period by registered nurses and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 26 June 2024	09:00hrs to 17:00hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what the inspector observed, there was evidence that the residents living in the centre received good quality medical care and support. However, it was of significant concern to the office of the chief Inspector that at the time of this inspection, there was no named person in charge in the centre. In addition, the governance structures and reporting arrangements were not clear. The provider had a history of non-compliances with the regulations and had previously been engaged in an escalated process with the office of the chief inspector. As identified on previous inspections, the centre operated a largely medical model of care. In the preceding period, some efforts had been made to embed a social model of care. However, due to issues with staffing resources and availability of transport, it was difficult for staff to support residents to access activities within the community. Other areas for improvement were identified in relation to reviews of personal support plans, staff training and supervision, and fire evacuation procedures.

The centre had originally comprised of two separate units, the Elm and Lisbri units and was registered for a total of 26 adult beds. However, in 2020 the provider reconfigured the service and applications to vary the conditions of registration were granted. This resulted in the foot print of the centre being reduced from two to one unit (the Elm Unit) and the number of residents accommodated being reduced to seven. A separate registration application from a new provider to become the registered provider for the other unit (Lisbri) was also granted.

At the time of this inspection, there were six residents living in the centre and there was one vacancy. The centre comprised of a seven bed roomed unit on a hospital based campus. Residents living in the centre ranged in age from 42 to 82 years. The majority of the residents had been living in the centre or in another centre within the campus for an extended period. There had been one recent admission to the centre in February 2024. A largely medical model of care was being operated and registered staff nurses were on duty at all times to meet the residents' care and support needs. A medical director and medical officers were accessible on the campus.

Over the course of the inspection, the inspector met briefly with each of the six residents. Warm interactions between the residents and staff caring for them was observed. The majority of the residents were unable to tell the inspector their views of the service but they appeared in good form and comfortable in the company of staff. One of the residents told the inspector that they were happy living in the centre and that staff were kind and helpful to them. An ice cream van made its weekly visit to the centre on the day of this inspection and residents were observed to enjoy ice cream cones with staff.

There was an atmosphere of friendliness in the centre. A holistic therapist was present on the morning of inspection and completed some holistic therapy and massage with five of the residents. One of the residents had a visit from a family

member and were observed going for a walk within the campus and spending time in the back garden as it was a sunny day. Numerous photos of residents were on display. Staff were observed to interact with residents in a caring and respectful manner and to respond kindly to their verbal and non verbal cues. For example, a staff member was observed knocking before entering a residents room and providing a resident support with eating in a kind and dignified manner. Signs were noted on bedroom and bathroom doors to alert others when care was being delivered.

As identified in previous inspection reports, the centre had an institutional feel. However, efforts had been made to give the centre a more comfortable and homely feel. Each of the residents had complex medical needs which necessitated the use of a various pieces of medical equipment. There were two separate storage areas for medical equipment when not in use.

The centre had adequate space for residents with good sized communal areas. There was a dining, come day room area, a separate large family room and a multi-sensory room. An industrial style kitchen was in place but all cooked meals were prepared in a separate kitchen within the campus and transported to the centre. There was a private patio and garden area to the rear of the centre which had recently been renovated. There were a number of colourful flower pots and a bird feeder on display. Five of the seven resident bedrooms had exit doors off their room, leading to the back garden and seating area. Each of the residents had their own bedroom with en-suite facility. Residents' bedrooms had been personalised with personal photos and some other items of their choosing. For example, one of the resident's bedroom was adorned with soft furnishing depicting butterflies which was a passion for this resident. This promoted residents' independence and dignity, and recognised their individuality and personal preferences.

Residents had access to advocacy services should they so wish. One of the residents had an independent advocate at the time of inspection. Staff had received some training on a rights based approach to care. A dignity 'do's and don'ts' poster was on display for staff reference. There was information on rights and advocacy services available. The charter of rights was detailed in the residents guide. There was evidence of consultations with residents regarding their care and the running of the centre. Residents' meetings were completed on a regular basis and there was evidence that residents rights and advocacy was discussed at these meetings.

There was evidence that residents and their representatives were consulted with and communicated with, about decisions regarding their care, the running of their home. Each of the residents had regular one-to-one meetings with their assigned key workers. Residents were supported to communicate their needs, preferences and choices at these meeting in relation to activities and meal choices. The inspector met with a relative of one of the residents who informed the inspector that they were extremely happy with all aspects of the care and support that their loved one was receiving. The provider had completed a survey with some relatives which indicated that they were happy with the care being provided for their loved ones. There was a comment book inside the front door and positive comments were noted

to have been recorded there.

Residents were supported and encouraged to maintain connections with their friends and families through a variety of communication resources, including video and voice calls and visits to the centre. There was no restriction on visiting to the centre.

While recognising that the residents had complex medical and support needs, it was considered that the residents were supported to engage in some but on occasions limited meaningful activities in the centre. The staff team included one activity team member who worked Monday to Friday during core working hours. This activity support staff member supported residents to engage in activities of their choosing. However, this staff member did not work at weekends and there was limited cover for the individual when they were on leave. Examples of activities that residents engaged in included, foot and hand massage, story reading, arts and crafts, watching television, gardening, knitting, listening to radio, personal grooming treatments, walks within the hospital campus, family visits, bird feeding and some board games. A weekly schedule of activities was displayed on the notice board in the day room and hallway. At the time of inspection, the centre did not have its own dedicated vehicle. In addition, the centre did not have access to a vehicle within the campus. The vehicle previously accessed from within the wider campus had been out of service for a number of months. Transport was sourced by the centre through an external company which required pre booking and coordination by staff in the centre. Consequently, coupled with staffing resourcing issues in the centre, it was sometimes difficult for staff to facilitate residents to access regular activities in the community.

The majority of the staff team had been working in the centre for an extended period. This meant that there was consistency of care for residents and enabled relationships between residents and staff to be maintained. Each of the residents had two assigned keys workers, one being a registered nurse and the other a healthcare assistant. The inspector noted that residents' needs and preferences were well known to staff and the clinical nurse manager.

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

Capacity and capability

At the time of this inspection, there was no named person in charge for the centre, contrary to the requirements of the regulations. In addition, the governance and reporting structures in place were unclear. This meant that the provider could not be assured that the service provided was safe, consistent and appropriate to residents' needs. Other areas for improvement were identified in relation to the annual report of the quality and safety of the service, staff training, staff supervision and staff

rosters.

A new person in charge had not been appointed following the resignation of the previous person in charge. It was reported that recruitment for a new person in charge was being hindered by unclear governance and reporting structures. There was a clinical nurse manager grade 2 (CNM 2) in place who had protected hours of two days per week to perform management duties, with the remaining hours being scheduled on duty for resident care needs. There was a clinical nurse manager, Grade 1 (CNM1) listed on the roster for the centre but they were not completing the hours recorded in the centre as they were working in a different area and had not commenced working in the centre since the resignation of the previous CNM1.

The management structure was not clearly defined in terms of accountability and responsibility. This meant that a number of staff were not clear on their responsibilities and who they were accountable to. The CNM2 reported that although she felt supported in her role, the centre's governance and organisational structure had recently been altered. Consequently, the reporting structure for the CNM2 was unclear and the CNM2 was not receiving formal supervision from a direct line manager. The CNM 2 was supported by senior staff nurses. As referred to above there was a vacant position for a CNM 1. The CNM2 and assistant director of nursing held meetings on a regular basis.

The provider had failed to complete an annual review of the quality and safety of the service in line with the requirements of the regulations. An unannounced visits, to review the safety of care had been completed. The CNM2 had completed weekly quality and safety walk arounds. A number of other audits and checks had also been completed. Examples of these included, infection prevention and control, hand hygiene, care plan, medications, health and safety checklist and finance. There was evidence that actions were taken to address issues identified in these audits and checks. There were regular staff meetings and separately quality patient safety management meetings which the CNM2 attended. There was evidence of communication of shared learning at these meetings.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. However, at the time of inspection there were two staff vacancies. These were being covered by staff working in other areas of the campus or on occasions agency staff. It was noted that the centralised nursing administration coordinated staff cover across the campus but there were times when cover was not always available. Although efforts were made to use regular staff who were familiar with the centre, this was not always possible and consequently there was a potential to have a negative impact on the consistency of care for the residents. In addition, staff issues sometimes hindered residents engaging in activities within the community.

A sample of four staff files were reviewed and found to contain all of the information required by the regulations. There were actual and planned duty rosters. However, these were found to record the name and working hours for a CNM1 who didn’t work in the centre. Consequently the rosters were not found to be maintained to a

satisfactory level.

Some training had been provided to staff to support them in their role and to improve outcomes for the residents. However, two staff were overdue to attend training in manual handling and in fire safety. A training programme was in place and coordinated by the provider's education and training officer. There was a staff training and development policy. There were no volunteers working in the centre at the time of inspection. Staff supervision arrangements were in place. However, staff supervision was not being undertaken in line with the frequency proposed in the providers policy. It was noted that staff performance achievement records had recently been completed for some but not for all staff. This meant that staff may not have been adequately supported to perform their duties to the best of their abilities.

A record of all incidents occurring in the centre was maintained and where required, these appeared to be notified to the Chief Inspector, within the timelines required in the regulations. However, the provider failed to give notice in writing to the office of the chief inspector of the absence of a person in charge as required by the regulations.

Regulation 14: Persons in charge

Contrary to the requirements of the regulations, there was no named person in charge working in the centre. It was reported that recruitment for a new person in charge was being negatively impacted by unclear governance and reporting structures.

Judgment: Not compliant

Regulation 15: Staffing

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. However, there were two staff vacancies at the time of inspection. These vacancies was being covered by staff working in other areas of the campus or on occasions agency staff. It was noted that the centralised nursing administration coordinated staff cover across the campus but there were times when cover was not always available. Although efforts were made to use regular staff who were familiar with the centre, this was not always possible and consequently there was a potential to have a negatively impact on the consistency of care for the residents and resourcing issues hindered residents engaging in activities within the community.There were actual and planned duty rosters. However, these were found to record the name and working hours for a CNM1 who didn’t work in the centre. Consequently the rosters were not found to be maintained to a satisfactory level.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided to staff to support them in their role and to improve outcomes for the residents. However, two staff were overdue to attend training in manual handling and in fire safety. Staff supervision was not being undertaken in line with the frequency proposed in the providers policy. It was noted that staff performance achievement records had recently been completed for some but not all staff.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a directory of residents in place which was found to contain all of the information required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Suitable governance and management arrangements were not in place. The centre/s governance and organisational structure had recently been altered. Consequently, the governance and reporting structures in place were unclear. This meant that the provider could not be assured that the service provided was safe, consistent and appropriate to residents' needs. The provider had failed to complete an annual review of the quality and safety of care in the centre in line with the requirements of the Regulations

Judgment: Not compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place, dated June 2024. This document stated that the person in charge position was vacant. However, it also stated that the CNM2 reported to the person in charge which was incorrect.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the office of the chief inspector in line with the requirements of the regulations.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider failed to give notice in writing to the office of the chief inspector of the absence of a person in charge as required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were appropriate complaint procedures in place. Information about the complaint procedure was on display in the centre. There was a nominated complaint officer. Staff spoken with were aware of the complaint procedure and the process was discussed with residents as part of house meetings. Contact details for the confidential complaint recipient were available in the centre. There had been no complaints in the preceding 12 month period.

Judgment: Compliant

Quality and safety

The residents living in the centre appeared to receive medical care and support which was of a good quality and person centred. However, improvements were required regarding the residents social care needs, procedures in place to review individual person centred plans and fire evacuation arrangements.

Residents living in the centre had complex medical needs. Overall, the residents' medical needs and welfare was maintained by a good standard of evidence-based care and support. Personal support plans reflected the assessed needs of individual

residents and outlined the support required in accordance with their individual health and personal care needs. It was noted that some goals had been identified for individual residents. However, these goals were not considered to be specific or measurable. For example, a goal identified for one resident was to' attend activities appropriate to the resident to promote physical, emotional and psychological well being'. An annual review of each resident's personal plan had been completed. However, these reviews did not assess the effectiveness of the plans in place in line with the requirements of the regulations. A user friendly version of the personal plan was not available as required by the regulations..

The health and safety of the residents, visitors and staff were promoted and protected. Individual and environmental risk assessments had been completed and were subject to regular review. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents. Trending of all incidents was completed on a regular basis. This promoted opportunities for learning to improve services and prevent incidences.

Precautions were in place against the risk of fire. However, it was noted that an external side gate which was an identified evacuation route to the fire assembly point, was locked with a pad lock. The keys to open this lock were not readily accessible to all staff as they were held by the staff nurse in charge. This meant that in the event of fire, there was the potential for a delay in evacuating residents to a safe location. All other evacuation routes were clear. A procedure for the safe evacuation of residents in the event of fire was prominently displayed and a fire assembly point was identified in an area to the front of the centre. Each of the residents had a personal emergency evacuation plan which adequately accounted for the mobility and cognitive understanding of the individual resident. Fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks. Fire drills involving the residents had been undertaken and it was noted that the centre was evacuated in a timely manner.

There were procedures in place for the prevention and control of infection. The inspector observed that areas appeared clean. There were full time household staff in place who were responsible for cleaning. A cleaning schedule was in place which was overseen by the CNM2. Colour coded cleaning equipment was available. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. Specific training in relation to infection control had been provided for staff.

There were measures in place to protect residents from being harmed or suffering from abuse. There had been one safeguarding incident in the preceding period but it was not considered to be of concern and there were no active safeguarding concerns. Appropriate arrangements were in place to report and respond to any safeguarding concerns. The provider had a safeguarding policy in place. Intimate care plans were on file and these provided sufficient detail to guide staff in meeting the intimate care needs of the individual residents. Residents were provided with

appropriate emotional and behavioural support and their assessed needs were appropriately responded to. Residents did not routinely present with behaviours that challenge. There were a number of physical restrictions in place and these were subject to regular review.

Regulation 10: Communication

The majority of the residents were non verbal. Communication plans were in place to assist and support residents to communicate in accordance with their needs and wishes. A small number of residents did not have English as their first language but had a good understanding of spoken English. There was evidence that frequently used phrases from a resident's first language had been translated, printed and put on display in their bedroom.

Judgment: Compliant

Regulation 13: General welfare and development

While recognising that the residents had complex medical and support needs, it was considered that the residents were supported to engage in some but sometimes limited meaningful and interesting activities in the community. A weekly schedule of activities was displayed on the notice board. At the time of inspection, the centre did not have its own dedicated vehicle. In addition, the centre did not have access to a vehicle within the campus. The vehicle previously accessed from within the wider campus had been out of service for a number of months. Transport was sourced by the centre through an external company. This required pre booking and coordination by staff in the centre. Consequently, coupled with staffing resource issues in the centre, it was sometimes difficult for staff to facilitate residents to access regular activities in the community. The staff team included one activity team member who worked Monday to Friday during core working hours. This activity support staff member supported residents to engage in activities of their choosing. However, this staff member did not work at weekends and there was limited cover for the individual when they were on leave.

Judgment: Substantially compliant

Regulation 17: Premises

The centre was comfortable and homely. It was found to be overall in a good state of repair. The centre had recently been repainted and the flooring had been

replaced throughout. In addition a number of works and maintenance had been completed in the garden. Each of the residents had their own bedroom and there were adequate communal areas. It was noted that a significant amount of equipment was required for use by the residents. Two separate storage areas were in place for equipment.

Judgment: Compliant

Regulation 26: Risk management procedures

The health and safety of the residents, visitors and staff were promoted and protected. There was a risk register in place, and environmental and individual risk assessments had been completed. A quarterly review of all incidents across the wider organisation were undertaken at the provider's incident review group.

Judgment: Compliant

Regulation 27: Protection against infection

There were suitable procedures in place for infection prevention and control which were consistent with the standard for the prevention and control of healthcare associated infections. The inspector observed that areas appeared clean. There were full time household staff in place who were responsible for cleaning. A cleaning schedule was in place which was overseen by the CNM2. Colour coded cleaning equipment was available. Sufficient facilities for hand hygiene were observed. The centre has recently been repainted and flooring throughout the centre had been replaced.

Judgment: Compliant

Regulation 28: Fire precautions

Precautions were in place against the risk of fire. However, it was noted that an external side gate which was an identified evacuation route to the fire assembly point, was locked with a pad lock. The keys to open this lock were not readily accessible to all staff as they were held by the staff nurse in charge. This meant that in the event of fire, there was the potential for a delay in evacuating residents to a safe location.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' well being and welfare was maintained by a good standard of evidence-based care and support. It was noted that some goals had been identified for individual residents. However, these goals were not considered to be specific or measureable. For example, a goal identified for one resident was to' attend activities appropriate to the resident to promote physical, emotional and psychological well being'. An annual review of each residents personal plan had been completed. However, these reviews did not assess the effectiveness of the plans in place in line with the requirements of the regulations. A user friendly version of the personal plan was not available as required by the regulations..

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs appeared to be met by the care provided in the centre. Residents were supported by registered general nurses and healthcare assistants at all times. Medical cover was provided by a medical director and three medical officers who were based on the campus. There was a dedicated occupational therapy and physiotherapy resource. Referrals could also be made to dietetics and speech and language therapy as required. Individual health assessments and plans were in place. There was evidence that dietary guidance for individual residents was being adhered to.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents appeared to be provided with appropriate emotional support. Residents in the centre did not routinely present with behaviours that challenge. There were a number of physical restrictions in use and these were subject to regular review.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. There had been one safeguarding incident in the preceding period but it was not considered to be of concern and there were no active safeguarding concerns. Intimate and personal care plans were in place and provided a good level of detail to support staff in meeting individual resident's intimate care needs. Safeguarding information was on display and included information on the nominated safeguarding officer. There was a safeguarding policy and all staff had received safeguarding awareness training.

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	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cherry Orchard Hospital OSV-0003730

Inspection ID: MON-0034649

Date of inspection: 26/06/2024

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The current PIC role is vacant. An assistant director of nursing has been identified to transfer to Elm Unit and this person will take up the role of PIC in a full time capacity for this 7 bed unit. This staff member has the required management experience, whereby they have over three years management experience in a residential setting. They will commence in Elm Unit on the 5th August. The ADON will report into the General Manager in disability services for line management and will also have clinical governance/supervision from a Director of Nursing. This Director of Nursing sits within disability services with a Section 38 agency. The general manager will meet fortnightly with the ADON and CNM II for provider meetings to support the new management structure within Elm.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Issues to address: There are currently two vacant posts attached to the unit, these include a CNM1 and a Staff Nurse. There is approval to fill these posts and there are staff available to commence in the coming weeks. This will ensure that there is sufficient staffing within	

the unit and reduce use of agency. Filling these posts would also ensure consistency of staff who are familiar with the residents and establish strong relationships and effective care.

CNM I to commence week beginning 29th July.

The ADON and CNM II will ensure that rosters are accurate and represent actual staffing. Rosters will be planned two weeks in advance. The ADON and CNM II will ensure that staffing listed on the rosters are staff allocated to Elm unit only.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training:
At the time of inspection two staff were overdue manual handling and fire safety training.

These two staff members have received training dates for August for manual handling and fire safety. The CNM II will ensure training certificates are recorded in staff files.

Performance Achievement:
It was noted during the inspection that performance achievement was outstanding for some staff.

For the three outstanding staff members who require to complete performance achievement this has been scheduled with the CNM II and will be completed by end of August.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An annual review will be undertaken by the registered provider, by the end August 2024.

The Assistant Director of Nursing will take up the role of PIC, the ADON will report into

the General Manager and they will meet for provider meetings on a fortnightly basis. A new organizational chart detailing the new governance and management structure will be developed.

Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Issues to address: The Statement of purpose will be amended to include the new organizational structure, this will be completed by 17th August.	
Regulation 32: Notification of periods when the person in charge is absent	Not Compliant
Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent: The registered provider will ensure that any periods of absence will be notified to HIQA immediately.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: Issues to address: Currently activity support staff are available Monday- Friday only. The CNM II is to review the roster with a view to allocating a resource to Saturday or Sunday. Access to vehicle- The vehicle available on cherry orchard campus has been repaired and is available to Elm Unit two days per week- Wednesday and Friday.	

In addition Elm Unit can book and schedule transport with Lucan Disability Transport. A framework PO has been set up with the finance department to ensure ease of booking.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Issues to address:
It was noted during the inspection that there was a padlock on the external side gate and this was also identified as an evacuation route.

In order to ensure that the gate can be unlocked in the event of an emergency the following control measures are in place:

Nurse in charge has a key on their person.
A second key has been organized and located in the key box in the nursing office.

By the end of August 2024 all staff will be up to date with their fire training.

By end of August 2024 a key box with code will be installed on the building beside the side gate and all staff allocated to Elm Unit will know the code for the key box.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Each resident has a nominated staff nurse to support the development and regular review of a personal plan. The personal development plans will be reviewed and personalized regarding the individual needs and preferences of the residents, taking into account their health, personal, family, and cultural background. This review of all personal plans will be completed by the end of August 2024. The CNM II will ensure this target it reached.

Each personal plan will be completed in a person-centred way and a user friendly version compiled for the resident and families.

Personal plans will be reviewed regularly thereafter (6 monthly) and updated based on feedback from the resident and their families.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/08/2024
Regulation 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	30/08/2024
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	Substantially Compliant	Yellow	30/08/2024

	size and layout of the designated centre.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	30/08/2024
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	30/08/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/08/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/08/2024
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre	Not Compliant	Orange	30/08/2024

	that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/08/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	30/08/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	30/08/2024
Regulation 32(1)	Where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more, the registered provider shall give notice in writing to the chief	Not Compliant	Orange	26/07/2024

	inspector of the proposed absence.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/08/2024
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 needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/08/2024