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:	Tí Geal Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	25 January 2023
Centre ID:	OSV-0004074
Fieldwork ID:	MON-0036559

About the designated centre

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

The designated centre provides a residential and respite service for up to six adults who have an intellectual disability. The centre can cater for residents with some medical healthcare needs, behaviour that is challenging and who may also attend the services of the mental health care team. A combination of social care workers and care assistants support residents during day and night-time hours.

The centre is a two-storey house which is located in a suburban area of a large city. Each resident has their own bedroom and there is also ample communal, kitchen and dining facilities for residents. Public transport links are available to residents and transport is also made available by the provider.

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 25 January 2023	09:30hrs to 16:30hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations.

On arrival at the centre, staff on duty guided the inspector through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene and face covering.

The inspector met with six residents who were living in the centre, staff members on duty and the person in charge.

The centre comprises a purpose built detached house located in a residential area close to a large city. The house was designed and laid out to meet the number and needs of residents. It was spacious, bright, visibly clean and furnished in a homely style. Each resident had their own large bedroom. There were five bedrooms located on the ground floor and two located on the first floor. Some residents showed the inspector their bedrooms which were decorated and furnished in line with individual preferences.There was adequate storage space for personal belongings and rooms were personalised with family photographs and other items of significance to each resident. Some of the bedrooms had been recently refurbished and redecorated. Residents had been involved in choosing their preferred colours, soft furnishings and bedroom furniture. There were an adequate number of toilets and showers located on each floor. There was a variety of communal day spaces available including a kitchen, dining room, large sitting room and two smaller relaxation rooms for use by residents. There was a separate utility room and an external store.

While the house was found to be warm and comfortable, there were were a number of items that had been identified and logged as requiring fitting, repair and maintenance that still had not been addressed. Some items such as repairs and upgrade to bathrooms, fitting of grab rails and curtain poles had been logged since March 2022. A new fitted kitchen had been provided since the previous inspection. Painting of the kitchen was taking place on the day of the inspection however, the walls had yet to be tiled.

On the morning of the inspection, the inspector met with two residents who were getting ready to leave the centre and attend their day service. Four other residents had already left to attend their respective day services. Both residents were observed having their preferred breakfasts in the dining room. They told the inspector how they liked living in the centre and looked forward to attending day services. One resident spoke about enjoying breakfast in a local restaurant in line with his usual Friday morning routine. The inspector met with all residents later in the afternoon when they returned to the centre. Some residents were unable to tell the inspector their views of the service but appeared content and comfortable in their environment and in the company of staff. Staff were observed to be attentive, spending time and interacting warmly with residents. Residents appeared to be good

form as they greeted and chatted with staff in a friendly and familiar manner. Residents set about their own routines, some relaxed on the sofa in the sitting room, another relaxed in their bedroom while others were supported to get drinks and snacks. Staff were observed to respond promptly to residents requests for support and information. For example, staff supported a resident to make a phone call to a family member, support a resident go for a walk and provided information on the staffing roster. Some residents showed their delight when reviewing the staff roster and indicated that they were happy to be supported by staff who were rostered on duty.

While there were stable staffing arrangements in place and staff were well known to the residents, there was only one staff member of duty when the inspector arrived on the morning of inspection. The planned roster showed that two staff were due to be on duty from 8am. Staff on duty advised that the night staff staff member who was due to finish at 9am had remained on duty until 9.30 am. One resident was assessed as requiring 1:1 support, therefore, one staff member could not provide this support and meet the needs of other residents. This is discussed further under the capacity and capability section of this report.

Residents spoke about looking forward to their evening meal which was being prepared by staff. They told the inspector how they choose their preferred meal options on a weekly basis. Residents were also supported to eat out and get takeaway meals. Some residents had been reviewed by the dietitian and speech and language therapist(SALT). Staff were knowledgeable regarding the nutritional needs and dietary requirements of residents. Staff had completed training on feeding, eating, drinking and swallowing difficulties (FEDS).

Residents and staff spoken with, documentation and photographs reviewed indicated that residents continued to be supported to partake in a variety of activities that they enjoyed both in the centre and in the local community. The centre was located in an area with good access to a range of facilities and amenities. There was easy access to a range of shops, restaurants, coffee shops, post office, pharmacy and other businesses. Residents spoken with and staff reported that residents enjoyed going for walks, drives, day trips, shopping, eating out, going for coffee, going to the cinema and bowling. Residents also enjoyed spending time at home relaxing, listening to music, watching videos on 'You Tube' and some enjoyed helping out with various household tasks.

Residents enjoyed meeting with and visiting family members. Some residents went home to stay with family members on a regular basis while others went home for day visits. Visiting to the centre was being facilitated in line with national guidance. There were no visiting restrictions in place and there was adequate space for residents to meet with visitors in private if they wished. Staff confirmed that visitors were welcome, some residents received visits from family members on a regular basis. The entrance hall was supplied with a hand sanitising dispenser unit and signage was displayed as a reminder to sanitise hands.

The inspector also noted that residents had their own centre specific charter of rights on display which outlined topics such as independence, privacy, right to

complain and being treated with respect. The charter of rights notice board was clearly displayed in the dining room and gave residents the opportunity to determine what was important to them and how their rights should be promoted. The complaints procedure and guide to making a complaint were clearly displayed in an easy read format. The details and contact information for the confidential recipient were also displayed.

In summary, the inspector observed that residents were treated with dignity and respect by staff. Staff were very knowledgeable regarding the individual needs, likes, dislikes and interests of the residents. It was evident that staff prioritised the welfare of residents, and that they ensured residents were supported to live person-centred lives.

The next two sections of the report outline 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 residents lives.

Capacity and capability

This unannounced inspection carried out to monitor ongoing compliance with the regulations. The inspector noted that issues identified at the last inspection had been addressed.

While the local governance and management team strived to ensure a quality service, some improvements were required to ensure that the service is adequately resourced to ensure effective delivery of care and support and to ensure that the service is safe, consistent and effectively monitored. Improvements were required to staffing arrangements, on-call management arrangements, to ensuring that maintenance issues escalated were addressed in a timely manner, to some aspects of fire safety management, to personal planning documentation and ensuring timely access to occupational therapy (OT) services.

There was a clearly defined management structure in place. A new person in charge had been appointed to the role in September 2022. they worked full-time in the centre. They had the necessary experience and qualifications to carry out the role. They were knowledgeable regarding the assessed needs of residents and strived to ensure that good quality of care was provided. They were supported by the assistant director of client services. The statement of purpose required updating to reflect changes to the management team and to the working arrangements of the person in charge in the centre. There were arrangements in place for out of hours on-call management arrangements during weekends, however, there were no formal on-call arrangements in place to ensure that staff were adequately supported out of hours during the weekdays.

Staffing arrangements required review to ensure that the assessed support needs of all residents could be met. The planned roster indicated that there were normally 2

staff on duty in the morning time, three staff on duty in the afternoon and evening until 21.00 hours and one staff member on duty at night time up to 9am. However, on the morning of inspection, there was only one staff on duty. Staffing rotas reviewed showed that there were occasional days when there were one staff member on duty in the morning time. The person in charge advised that there were no current staffing vacancies but that it was sometimes difficult to get relief staff to cover sick leave at short notice. While there were a number of relief staff identified, many of these staff were working part-time in other centres and not always available.

Training was provided to staff on an on-going basis. Records indicated that all staff including relief staff had completed mandatory training. Staff spoken with confirmed that they had completed mandatory training including fire safety, safeguarding and behaviour management. Additional training in various aspects of infection control, epilepsy, administration of medications and respiratory emergency had also been provided to staff. The person in charge had reviewed training requirements, updated the training matrix and further training was planned. However, additional training on restrictive practice as recommended following a review and investigation into a number of safeguarding incidents had not yet been completed by staff.

The provider had failed to ensure that systems in place for logging requests for maintenance were effective and acted upon in a timely manner. Issues identified in the centre that required repair and maintenance were logged on a computerised system(Flex), however, these issues were not addressed in a timely manner which posed a risk to residents. The person in charge had followed up on requests by email but many issues were still outstanding.

The provider had carried out unannounced inspections of the centre and provided a written report on the safety and quality of care. Reviews had taken place in April and December 2022. The provider had identified the outstanding maintenance issues during both reviews but all of these issues had still not been addressed. The person in charge advised that the annual review on the quality and safety of care for 2022 was in progress and due for completion by the end of January 2023, however, there was no annual review available for 2021.The person in charge continued to review areas such as staff training, restrictive practices and had completed monthly reviews of medication management, risks and incidents.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives. They worked full-time in the centre. They were positive in attitude and showed a willingness to comply with the regulations. They were well known to residents and staff in the centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing arrangements required review to ensure that the assessed support needs of all residents could be met. On the morning of inspection, staffing levels were not in line with the planned roster and there was only one staff on duty. Staffing rotas reviewed showed that there were occasional days when there were one staff member on duty in the morning time. While there were a number of relief staff identified on the roster, the inspector was advised that many of these staff were working in other centres and were unavailable at short notice.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Additional training on restrictive practice as recommended following a review and investigation into safeguarding incidents had not yet been completed by staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required to ensure that the service is adequately resourced to ensure effective delivery of care and support and to ensure that the service is safe, consistent and effectively monitored.

- Systems in place for oversight of maintenance and repair works required review. Issues identified and logged were not addressed in a timely manner which posed a risk to residents and staff.
- Arrangements in place for out of hours on-call management arrangements at weekends required review to ensure that staff were adequately supported out of hours during the weekdays.
- Staffing arrangements required review to ensure that the assessed support needs of all residents could be met on all shifts.
- An annual review on the quality and safety of care in the centre for 2021 was unavailable in the centre.
- Further oversight was required in relation to some aspects of fire safety management, to personal planning documentation and to ensuring timely access to occupational therapy (OT) services.

Judgment: Not compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was unavailable in the centre. The statement of purpose required updating to reflect changes to the management team and to the working arrangements of the person in charge in the centre.

Judgment: Substantially compliant

Quality and safety

The local management team and staff strived to ensure that residents received an individualised, safe and good quality service, however, as discussed under the capacity and capability section of this report, improvements required in relation to governance and management had the potential to impact negatively on the quality and safety of the service provided. Improvements were also required to some aspects of fire safety management, repair and maintenance works to the premises, personal planning documentation and access to OT services.

Staff spoken with and files reviewed indicated that residents were generally in good health and that identified health conditions were stable. The inspector reviewed a sample of residents files and noted that they were informative, however, some inconsistencies were noted. It was evident in some files reviewed that the residents health, personal and social care needs had been assessed and regularly reviewed. Annual meetings were held with residents and their family representatives where appropriate. Goals were clearly set out and included details of the person responsible for supporting the resident achieve each goal. A progress report was completed which showed that many goals were being achieved. However, one of the files reviewed required updating. While specific health care needs had been identified and staff were knowledgeable regarding the conditions and supports required, there were no corresponding care plans in place to reflect the supports being provided. This resident had not had a recent case review, the last recorded review took place in January 2021 and there was no record of goals set by the resident for 2022.

Staff spoken with and files reviewed indicated that residents had timely access to a range of health care services with the exception of occupational therapy (OT). Residents had timely access to General Practitioners (GPs), out of hours GP service, consultants and a range of allied health services. A review of a sample of residents files indicated that residents had been reviewed by the psychiatrist, SALT, dietitian, psychologist, chiropodist, and dentist. Residents had also been supported to avail of vaccination programmes. Files reviewed showed that residents had an annual

medical review. Each resident had an up-to-date hospital passport which included important and useful information specific to each resident in the event of they requiring hospital admission.

The inspector reviewed documentation relating to safeguarding incidents that had been notified to the Chief Inspector during July 2022. The inspector was satisfied that they had been managed and investigated in line with the safeguarding policy. There were a number of recommendations as a result of the review which had generally been implemented in the centre. However, further staff training in relation restrictive practices as recommended had not yet taken place.

There was guidance in place to support residents with their behaviours of concern. Staff were knowledgeable regarding these recommendations and all staff had received training in managing behaviours of concern. The person in charge reported that supports were available to residents and staff from the psychologist and behaviour therapist. Regular reviews had taken place and further reviews were scheduled for February 2023. The person in charge continued to review restrictive practices to ensure that the least restrictive practices were in use. Documentation to support the use of restraint was in line with national policy.

Improvement was required in relation to some aspects of fire safety management. While the staff demonstrated good fire safety awareness including knowledge of the evacuation needs of residents, further clarity was required in relation to the workings of the fire alarm panel. Several fire doors were also found to be wedged open with items of furniture. Staff confirmed that automatic door release systems were not in working order. This posed a risk to residents and staff due to the potential spread of uncontrolled smoke throughout the building in the event of fire. The person in charge had identified and logged this issue on 11 November 2022 as requiring repair or replacement, however, it had not been addressed. Daily, weekly and monthly fire safety checks continued to take place. The fire equipment and fire alarm had been regularly serviced. Regular fire drills had taken place indicating that residents could be evacuated safely and in a timely manner.

The house was designed and laid out to meet the number and needs of residents. It was spacious, comfortable, visibly clean and furnished in a homely style. However, the provider had failed to ensure that systems in place for managing requests for maintenance were effective and acted upon in a timely manner. Issues identified in the centre that required repair and maintenance were logged on a computerised system(Flex), however, many issues were not addressed in a timely manner which posed a risk to residents. The person in charge had followed up on requests by email but many issues were still outstanding.

The providers systems in place for responding to identified risk as outlined under Regulation 23: Governance and management and Regulation 28: Fire precautions required review. The person in charge continued to complete a review of risks on a monthly basis. Risks identified in the most recent review included staffing, fire safety and infection prevention and control. Residents personal emergency evacuation plans (PEEPs) had been recently updated.

Regulation 11: Visits

Visiting to the centre was being facilitated in line with national guidance. There was plenty of space for residents to meet with visitors in private if they wished. There were no restrictions on visits at the time of inspection. Residents were supported to maintain regular contact with their families and regularly visited family members at home.

Judgment: Compliant

Regulation 17: Premises

The provider had failed to ensure that systems in place for logging requests for maintenance were effective and acted upon in a timely manner. Issues identified in the centre that required repair and maintenance were logged on a computerised system(Flex), however, these issues were not addressed in a timely manner which posed a risk to residents. The person in charge had followed up on requests by email but many issues were still outstanding. The provider had identified the outstanding maintenance issues during reviews of the service in April and December 2022 but all issues had still not been addressed.

Examples of issues identified as requiring repair and maintenance on the day of inspection included:

- Some fire doors not closing automatically / release mechanisms not in working order
- Rusted grab rails in bathroom
- Rusted radiator covers in bathroom
- Defective side panel on bath
- Defective shower head in shower room
- Refrigerator in kitchen unsteady
- Defective paintwork to wooden skirting boards in dining room
- New grab rail to be fitted to bath
- Three curtain poles to be fitted to residents bedrooms
- Defective garden shed to be removed.

Judgment: Not compliant

Regulation 26: Risk management procedures

The providers systems in place for responding to identified risk required review. This

action is outlined under Regulation 23: Governance and management and Regulation 28: Fire precautions. The person in charge continued to complete a review of risks on a monthly basis. Risks identified in the most recent review included staffing, fire safety and infection prevention and control. Residents personal emergency evacuation plans (PEEPs) had been recently updated.

Judgment: Compliant

Regulation 28: Fire precautions

Improvement was required in relation to some aspects of fire safety management. Further clarity was required by staff in relation to the workings of the fire alarm panel and to the room descriptors identified on the panel in the event of fire. The room descriptors listed and displayed adjacent to the fire panel did not correspond with the room descriptions as set out in the layout plan of the centre which was also displayed beside the fire panel. This posed a risk in the event of fire and could lead to confusion and delay in locating a fire. Several fire doors were found to be wedged open and staff confirmed that some automatic door release systems were not in working order. The person in charge had identified and logged this issue on 11 November 2022 as requiring repair or replacement, however, the provider had failed to ensure that these works were addressed promptly. This posed a risk to residents due to the potential spread of uncontrolled smoke throughout the building in the event of fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Improvements were required to some personal planning documentation. The inspector noted that one of the files reviewed required updating. While specific health care needs had been identified and staff were knowledgeable regarding the conditions and supports required, there were no corresponding care/support plans in place to reflect the supports being provided. The resident had not had a recent case review, the last recorded review took place in January 2021 and there was no record of goals set by the resident for 2022.

Judgment: Substantially compliant

Regulation 6: Health care

Improvements were required to ensure that where a resident required the services of occupational therapy(OT) that such services were provided in a timely manner. A review of a residents file indicated that a referral had been sent for OT in February 2021 and follow up emails sent in February and November 2022 had still not been provided with a review.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Resident's individual behavioural support plans were kept under regular review and staff had a good knowledge of assisting residents with their behavioral needs. All staff had received training in managing behaviours of concern. There were some restrictive practices in place and the inspector was satisfied that they were being managed in line with national policy. For example, there were risk assessments in place for all restrictions in use, there were protocols in place which clearly outlined the rationale for their use and records were maintained of when they were used. There was restricted access to the kitchen for one of the residents, however, an activated door lock was in use which did not limit other residents from accessing the kitchen.

Judgment: Compliant

Regulation 8: Protection

All staff had received specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm. There were detailed personal and intimate care plans to guide staff. The support of a designated safeguarding officer was also available if required. Safeguarding concerns notified to the Chief Inspector in July 2022 had been investigated in line with safeguarding policy.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tí Geal Services OSV-0004074

Inspection ID: MON-0036559

Date of inspection: 25/01/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Person in Charge is reviewing the staff rota with the Person Participation in Management on a weekly basis to ensure there are adequate staff resources available and on the rota to meet the assessed needs of the residents at all times. The Person in Charge will submit evidence of the staffing Rota to the Person Participating In Management. Ability West are currently recruiting staff to ensure that a relief staff member is allocated to Ti Geal : Completion date: 30th May 2023	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: An information and Training session with reference to Restrictive Practices will be completed by the 02 March 2023. Restrictive Practices will be a standing agenda item on all Ti Geal staff team meetings effective from March 2023	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Person in Charge and Person Participating in Management will be reviewing and monitoring the governance and management issues on weekly basis at the weekly scheduled meetings.	

All maintenance issues identified in the inspection report have been completed as at 17th February 2023 with the exception of the painting which is still in progress.

Maintenance and overview of all outstanding maintenance requests will be an agenda item on the weekly meeting between the Person in charge and person participating in management, as scheduled.

Person in Charge will review the staff roster with the PPIM on a weekly basis to ensure there is adequate staffing to meet the assessed needs of the residents .

Annual review for 2022 has been completed and was available in the Centre but it had the incorrect date on it. This date on the annual review has now been corrected.

The fire safety doors releases have had the batteries replaced and are now in working order and this was completed on 25th January 2023. The fire panel and room descriptors have been reviewed and correspond with the room descriptions in the layout plan for the Centre

The care and support plan for the resident has been updated by the key worker and reviewed by the PIC. The Assessment of need has been completed.
A Sensory assessment has been booked with a Private Occupational Therapist for August 2023

A revised 7/7 on-call structure has been identified by the Senior Management Team, and arrangements for this are currently being finalised. It is intended that the new on-call arrangements will be communicated across services and implemented by end of March 2023.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose has been updated and submitted to HIQA

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All maintenance issues identified in the inspection report have been completed as at 17th February 2023 with the exception of the painting which is still in progress.

Maintenance and overview of all outstanding maintenance requests will be an agenda item on the weekly scheduled meeting between the Person in charge and person participating in management.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The fire safety doors releases have had the batteries replaced and are now in working order and this was completed on 25th January 2023. The fire panel and room descriptors have been reviewed and correspond with the room descriptions in the layout plan for the centre

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The care and support plan for the resident has been updated by the key worker and reviewed by the PIC. All Care and support plans for all residents will be reviewed by end of April 2023, The Assessments of needs have been completed.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: Person in Charge and Person in Person Participating in Management has booked the Sensory assessment for the resident with a Private Occupational Therapist. The Provisional date received for this appointment is August 2023.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/05/2023
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	02/03/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/03/2023

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Orange	31/03/2023
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.	Substantially Compliant	Yellow	22/02/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Not Compliant	Orange	22/02/2023

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/03/2023
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	22/02/2023
Regulation 05(1)(b)	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 subsequently as required to reflect changes in need and circumstances, but	Substantially Compliant	Yellow	01/02/2023

	no less frequently than on an annual basis.			
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).	Substantially Compliant	Yellow	01/02/2023
Regulation 05(6)(a)	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 multidisciplinary.	Substantially Compliant	Yellow	01/02/2023
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.	Substantially Compliant	Yellow	01/08/2023