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:	Centre 6 - Cheeverstown Community Services (Templeogue/Kimmage)
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	28 June 2022 and 29 June 2022
Centre ID:	OSV-0004129
Fieldwork ID:	MON-0030707

About the designated centre

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

This designated centre comprises of four houses, all located between two towns in Co. Dublin. The centre provides full-time residential services to male and female residents with an intellectual disability. The designated centre has a capacity for 13 people in total. Within the centre there are three two-storey semi-detached residential homes and one bungalow. House one consists of three bedrooms, two toilets/shower rooms, a dining room, a sitting room and kitchen with a garden area out the back. House two consists of six bedrooms two of which are en-suite, one bathroom, a dining room, a kitchen and sitting room. House three consists of four bedrooms, one toilet and one bathroom and kitchen/dining area and a sitting room with a garden area out the back and house four consists of five bedrooms, one toilet and two toilet/shower rooms, a kitchen/dining area, a sitting room and a utility room and a garden space out the back of the house. There is accessible transport available on request for all houses. The person in charge shares their working hours between the four houses within the designated centre. There are nurses, social care workers and care assistants employed in this centre to support residents with their assessed needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Tuesday 28 June 2022	10:15hrs to 17:45hrs	Gearoid Harrahill	Lead
Wednesday 29 June 2022	09:40hrs to 15:00hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

During this unannounced inspection, the inspector had the opportunity to meet with all twelve residents living in designated centre, as well as speak with their direct support staff. The inspector also observed some of the residents' routines, and how they were supported, and interaction between them and their support team. Examples were observed during the inspection of how resident choices and preferred activities led the structure of their day, both in the house and in the community.

The designated centre consisted of four suburban houses registered to accommodate between two and four people each. Overall the layout of these houses was suitable for the support needs of the residents. Bedrooms were personalised based on each resident's preferences and interests. Living rooms, dining rooms and television rooms were comfortable and pleasantly decorated, however one communal area doubled as a staff office space which impacted upon the home-like appearance of the area. Residents had access to private external gardens. In one house there had been renovations to provide more storage space for clothes and personal belongings for residents in smaller bedrooms. The provider also had discussed plans for one person with a small bedroom to relocate into a vacant larger room and to decorate it based on their wishes.

Communal areas were nicely furnished, with homely decoration as well as residents' books, trophies, certificates, artwork and photographs. Some of the residents had done work with pottery, sketches and stained glass artwork and this was on display in their living rooms. One resident was attending an art exhibition with their day service and showed the inspector one of their creations for display. Another resident proudly showed the inspector their work on large complex jigsaw puzzles which had been framed and displayed around their home. Some of the residents were involved in advocacy groups and were planning to attend meetings for this during the inspection. Other residents were coming and going from their day service or workplaces. One resident had recently celebrated a milestone birthday and showed the inspector one of their gifts; a photo book with pictures of their childhood, their religious and social events, their favourite places, and their family, friends and housemates on outings.

Residents commented positively on their experiences working with the staff and the inspector observed a good rapport between the team and the residents during the inspection. Good examples were observed of staff members being familiar with residents' communication styles and gestures to support the resident and inspector to speak with each other. During times in which some residents were anxious or distressed, the staff were seen to listen patiently and give them time to express what was bothering them, and provide reassurance to them based on their knowledge of the person. The inspector found evidence that the regularity of staff deployed from the support panels had mitigated the impact on support continuity for residents. Both the core team in each house, and personnel on the relief

complement, demonstrated knowledge of residents' support needs, personalities, favourite foods and activities, interests and communication styles.

Residents were supported to travel by foot or using their mobility equipment in the local area, and by an accessible vehicle when travelling further. The houses had set times in the week during which they would have access to cars and could plan activities and outings around that schedule.

Residents' rights were respected in the use of safety features and restrictions, with evidence of how the provider was retiring or changing practices which were no longer required or not proportionate to the assessed level of associated risk. All resident were vaccinated against COVID-19 and were following general precautions, and as such were being supported to get out into the community and go on holidays and trips as the risk associated with the pandemic was reduced. Some improvement was required in encouraging and promoting residents to manage their day-to-day cash and medicines where it was determined that they could do so with reduced staff support, and the provider evidenced how they would be linking with the multi-disciplinary team to develop this and optimise opportunities for independence in the future.

The residents told the inspector that they liked their homes and got along well with their peers in general. One house had decreased in occupancy and a remaining resident commented that they enjoyed the more relaxed house with fewer housemates. Some residents commented that there were times when there was limited activities in the house or reduced opportunity to get out for a walk at times when there was only one staff member present in the house. This was also observed at one point by the inspector while some staff were off-site with other service users. One resident commented that they wanted work done in their garden based on their wishes. Residents of one house commented that the dining room was too small for the number and equipment needs of them and their housemates, and were observed having difficulty navigating the tight space. The inspector founded evidence of how commentary raised by residents was communicated, in writing, to the provider and management, with a record of what action would be taken and how this was relayed back to the service users. The provider had optimised the use of their house meetings, audits and complaints processes to ensure that the residents' voices were captured in how their home was operated.

The next two sections of this 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 being delivered.

Capacity and capability

The inspector found evidence indicating that the local and provider-level management had robust structures in place to facilitate proactive identification of

areas for development or enhancement. The majority of the findings for improvement on this inspection were already known to the provider, through effective use of audits and engagements with the staff and residents. Some minor improvement was required to ensure staff training and notification of adverse incidents was completed in a timely fashion.

The provider had conducted comprehensive audits to assess the regulatory compliance of the designated centre and the quality and safety of the service. These had been effective in identifying areas in need of development or improvement. The provider level management and the person in charge met regularly and the minutes of these meetings indicated that matters relating to the designated centre were being routinely reported to the provider. This included reflection on outcomes of fire evacuation practice, learning from safeguarding concerns, improvements to enhance the size, layout and maintenance of residents' personal and communal space, encouraging residents and staff to return to regular outings and visits as social restrictions ease, and discussion of feedback raised by residents in their homes.

Staff also met regularly to discuss matters which were meaningful to each house's occupants, including changes in their preferred routine, what holidays and events were coming up, and updates required to personal support plans. Staff meetings were themed around topics such as safeguarding and infection control to keep discussions varied and meaningful. Meetings also served as reminder to staff to attend outstanding training and to encourage prompt reporting of any potential concerns.

For the most part staff members were up to date on mandatory training such as fire safety, supporting residents' mobility or behavioural support needs, and safeguarding vulnerable adults. However there were outstanding training sessions related to topics such as medication management, and supporting people with dementia, epilepsy and autism.

The inspector reviewed a sample of supervision, probation and performance management records, which had taken place in accordance with provider policy. The person in charge had completed at least one performance management session with each member of their team in 2022, and for newer members of the front-line team, had meaningful reflection on areas in which they were doing well, and where they required additional support during their probation period.

Verbal and written complaints and feedback from residents was recorded in detail, with evidence of discussions and actions on the matter, and how the outcome was communicated back to the resident.

Regulation 15: Staffing

The inspector reviewed a sample of worked staffing rosters in the designated centre and found evidence that where staff were off-duty or on leave, they were covered by consistent and familiar relief and agency personnel to mitigate the impact on the

residents' support. Both regular and relief team members met on inspection demonstrated a good knowledge of residents' support needs and preferences.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector found evidence that staff members had been facilitated to attend supervision, probation and performance management sessions with their respective line manager.

Staff were facilitated to keep their training in mandatory skills such as fire safety, safeguarding of vulnerable adults and infection prevention and control up to date. However, there were a number of gaps in training required based on the assessed needs of residents, including support for people with autism or dementia. There were also some gaps in training for the safe administration of medication.

Judgment: Substantially compliant

Regulation 23: Governance and management

In the main, the provider's structures of management, oversight and auditing was effective in identifying and setting out specific action to address areas in need of development or improvement. The majority of the areas identified by the inspector for improvement in regulatory compliance had been identified through the provider's own quality and safety audits, including fire safety upgrades, staff training gaps and deficits in the premises' upkeep.

While it was noted that some of the person in charge's day-to-day duties could be challenging to maintain for four locations and when they were on leave, the direct support staff were familiar with who they could contact for advice or in emergencies out of hours. Examples were reviewed of how the provider supports and supervises their own team but also how they are aware of matters related to staff working in the designated centre who are managed through a separate structure such as the relief panel or housekeeping team.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed a sample of agreements of care and support which were

signed by the resident, or their representative, and the provider. These outlined the terms, conditions and fees associated with their residency.

Judgment: Compliant

Regulation 31: Notification of incidents

A number of events which had occurred in the designated centre requiring notification to the Chief Inspector had not been submitted within the required time frames, in some cases by a number of weeks.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector found good examples of how complaints, feedback and commentary raised by residents in their homes were referred to the appropriate personnel, with a clear record of actions taken and advice referred back to the complainant in a timely fashion.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had a suite of policies and procedures required under Schedule 5 of the regulations which had been revised within the required time frames.

Judgment: Compliant

Quality and safety

The inspector found evidence to indicate the residents' wellbeing and welfare was supported in their home and that their choices and preferences for routines and activities were respected in their daily support. Some improvement was required in the review of support plans to ensure that they were accurate, and were determined to be effective in achieving the intended outcome. Improvement was required in the upkeep of the premises to maintain a homely, attractive living space, as well as in

the fire safety infrastructure of the premises.

The inspector reviewed the assessments of support needs of the residents in the designated centre and found them to be detailed, evidence-based with appropriate input from the relevant healthcare professionals. The support plans developed from these assessments were detailed and written with consideration to the residents' history and preferences. While plans were reviewed on at least an annual basis, some of the information in support plans had not been updated to reflect changes. There was also some minor areas of contradiction between the details of the assessment and the associated support plan. While the inspector found that evaluation criteria of some support plans were detailed, other reviews contained minimal or no information on how the provider was assured of the plan's effectiveness in achieving their intended objective. Support delivery and interaction between staff and residents observed during the inspection reflected those described in support plans.

Where concerns related to the safeguarding of residents were witnessed or alleged to the staff team, they were reported promptly to the management and designated officer. The inspector reviewed examples of where immediate or short-term action was taken to ensure residents were safe while screening or investigation took place to determine the facts of the incident. The inspector found examples of where action had been taken based on the findings of the investigation. Whether substantiated or not, incidents were used as learning opportunities going forward. The provider had advised and involved the Health Service Executive safeguarding team or An Garda Síochána in line with their policy and regulatory requirements.

Overall the houses were safe and suitable for use by the residents, and through audits, observations and feedback from the residents and front-line staff, the provider had identified areas in which the living space could be further improved for residents, including providing larger bedrooms, improved storage solutions and easier navigation in communal areas. Among these included one dining room whose space was not adequate for residents to easily navigate. There were a number of areas in which general wear and tear had impacted on the homely and comfortable appearance of the residents' homes, as well as impacting on their ability to be effectively cleaned and sanitised, examples of which are detailed later in this report. Overall residents' living space was comfortably furnished and residents had sufficient space to personalise and decorate their bedrooms how they wished.

Staff were trained in fire safety practices, and residents and staff had been involved in practice evacuation drills to provide assurances that people could exit the building promptly in an emergency. The provider was achieving consistently low evacuation times including in scenarios simulating low staff levels. There was an emergency procedure described in each house detailing the routes, orders and support needs with which residents were facilitated to evacuate. Fire safety equipment was routinely serviced and the houses were equipped with emergency lighting, firefighting equipment and emergency packs. Where doors were locked at night, emergency keys were readily available. Improvement was required in the designated centre in the containment of the spread of flame and smoke. Rooms along evacuation routes were not all equipped with fire-rated doors, cold smoke

seals or self-closing devices to contain spread, including in areas of high fire and smoke risk such as kitchen and laundry areas. Some of the doors which did have these features were observed to be wedged open, instead of having features which allowed doors to be held open, by choice or necessity, without compromising their containment features. The registered provider had engaged the services of an independent fire safety consultant to identify works required to achieve compliance with the regulations for its designated centres. However, at the time of this inspection, this review and plan of works had not yet been completed for this designated centre, and as such, there was no evidence of a time bound plan to indicate when the provider would expect to come into compliance with the regulations.

Resident independence and positive risk taking was encouraged for the most part, and the provider had minimal environmental or safety restrictions in effect where risks were assessed as low. Residents were encouraged to stay involved in the community, meet with friends and family, go on holidays and weekend breaks as social restrictions related to the COVID-19 pandemic were lifted and people have received their vaccinations. The provider had conducted assessments determining where residents did and did not require staff support when managing their cash money and taking their medicines, and some residents had secure storage in their own living space for this reason. However, for some of the residents reviewed, it was unclear how staff were encouraging independence relative to the level of support assessed as required, as all wallets and medicines were locked in the staff office and given to residents by staff when required.

Residents were assessed for their level of independence with activities of daily living such as dressing, showering, shaving and eating, and were observed to only be supported to the appropriate degree required through these assessments. Residents took turns choosing their meals and the houses were well-stocked with a variety of healthy food, snacks and treats. Where residents required specific food modifications to control identified risks such as choking, the guidance from the speech and language therapist was clearly described and reminded to staff. Refrigerators were clean and all items inside were within their expiry date and labelled when opened. Residents had access to tea, coffee and biscuits, offering them to the visiting inspector as they chatted in their home.

Regulation 11: Visits

Suitable arrangements were in place for residents to receive visitors into their home with appropriate and proportionate precautions in place for same.

Judgment: Compliant

Regulation 12: Personal possessions

Residents' homes were suitably personalised and had adequate storage space for their clothes, books, games and other personal belongings.

Residents were supported to have access to their belongings and personal monies. However, for some residents assessed as having capacity to manage personal money with some staff support, it was unclear how independence to maintain control of same when in the house was being encouraged and supported.

Judgment: Substantially compliant

Regulation 17: Premises

The kitchen and dining area of one of the four houses was not ideal for the number of residents in the house along with their equipment and support staff. Residents and staff members commented that the space was too small for everyone to use comfortably and the inspector observed residents having difficulty navigating around the dining furniture with their equipment.

The dining area of another house doubled as office space for staff members, including a computer, printer, folders of documents and residents' personal plans, which impacted on the homely environment of the residents' living space.

In all four houses of the designated centre there were varying levels of work required to maintain the upkeep and cosmetic appearance of the residents' homes. Items observed by the inspector included, but were not limited to, the following:

- Walls which were cracked or scored with light to heavy damage to paint and plasterwork,
- Linoleum and carpet surfaces which were torn, worn or lifting,
- Broken kitchen tiles,
- Damage around wall vents and electrical sockets,
- Peeling and worn surfaces on kitchen units, bathroom cabinets and bedroom wardrobes,
- Radiators and skirting boards requiring repainting,
- Cracks along some kitchen and bathroom ceilings.

The provider had conducted detailed and comprehensive environmental audits and the observations listed related to the upkeep and layout of the houses had been identified by the provider and discussed in governance meetings to progress short-term and long-term work to address these items.

Judgment: Not compliant

Regulation 18: Food and nutrition

There was a plentiful supply of food, snacks and drinks for the number and preference of the residents. Resident choice in varied, nutritious meals as well and treats and takeaways was supported. Where residents required modifications to their meals due to dietary needs or risks such as choking, staff were provided clear and accessible guidelines and reminders on how to prepare and present the meals.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

In the case of a resident who had recently joined the designated centre, the inspector found evidence that risk assessments had been carried out to ensure the premises, support structures and impact on the existing residents was considered prior to the service user moving in.

Judgment: Compliant

Regulation 27: Protection against infection

Some aspects of the premises deficits impacted on the ability of some surfaces and environments such as in the kitchens and bathrooms to be effectively cleaned and sanitised.

The inspector found evidence to indicate how the provider had used the experience of an outbreak of COVID-19 as a learning opportunity to develop their preparedness and contingency arrangements going forward.

Staff followed correct procedures for hand hygiene and use of personal protective equipment. All equipment used for cleaning such as mops and buckets, cloths and vacuum cleaners were appropriately managed and stored, with guidance available to staff on the correct usage of equipment and chemicals based on where, and for what, they were used. Fridges, laundry areas, vehicles and medication stores were clean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

All areas were equipped with fire fighting equipment and emergency lighting which was routinely serviced. Practice evacuation drills took place for the provider to be assured that staff and residents followed efficient evacuation procedures in an emergency and these were achieving consistently low escape times.

Many of the evacuation routes were not effectively protected from fire and smoke, with doors not being rated to contain fire, seal smoke or self-close in an emergency, including doors entering high risk zones such as kitchens and laundry areas. A small number of doors, which were appropriately equipped to self-close, were observed to be wedged open rather than using a method which would still allow the door to close upon the fire alarm activating.

Staff were trained in fire safety procedures and were clear on processes to follow, for example when to call emergency services, what was the optimal order for resident evacuation, and where emergency keys and supplies were located.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The processes in place for the administration, recording, storage and disposal of medicines was appropriate, and staff demonstrated a good knowledge of the purpose and precautions associated with each medicine.

Residents were assessed to determine their level of capacity for managing their own medicines. The inspector reviewed a sample of these assessments and found examples of where residents were assessed as being independent to take most of their medicines and requiring only verbal reminders from staff, however for these people staff continued to manage medicines for them, and had not developed support structures to optimise and encourage independence relative to their assessed support needs.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of resident support plans and staff guidance on care delivery in each house of the designated centre. Overall, support plans were detailed, person-centred, written in a respectful fashion and were informed by a comprehensive assessment of need. the inspector found examples of where residents' commentary and changing circumstances resulted in review to these plans and how the multidisciplinary team were involved in their content. In the main, care

and support interactions observed during the inspection reflected those described in the personal plans.

There was a minority of instances in which the content of the personal plan had not been updated to reflect current circumstances, and instances in which the assessment of need did not accurately reflect the resident's support requirements. There was also mixed levels of detail on the evaluation of support plan effectiveness, with some reviews containing limited or no evidence of how the provider was assured that the support plan is achieving the intended objective.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found evidence indicting timely referral of residents for healthcare appointments and screening programmes. Residents had sufficient access to their doctor and to nursing support when required.

Judgment: Compliant

Regulation 8: Protection

Where alleged, suspected or actual incidents of resident abuse or safeguarding risk had been reported, the provider took prompt short-term action to ensure residents were safe while they initiated their investigation process. Allegations had been reported to the designated officer and there was evidence that the Health Service Executive safeguarding team were kept apprised of investigation progress. Whether or not allegations were substantiated, they were used for learning going forward. The inspector found examples of where actions had been taken on foot of safeguarding incidents and allegations.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector observed evidence of how residents' commentary, feedback and requests were recorded and discussed to contribute to decisions made in the designated centre. Staff were observed interacting with residents and supporting their routines in a respectful and dignified manner. Some residents were involved in an advocacy programme in which they discussed topics which were meaningful to

them and their peers.
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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Centre 6 - Cheeverstown Community Services (Templeogue/Kimmage) OSV-0004129

Inspection ID: MON-0030707

Date of inspection: 28/06/2022 and 29/06/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Safe administration of medication – 15 staff required SAM's training. 12 staff have completed and are in date, 1 staff on long term sick remaining 2 staff will have completed by October 28th 2022, 16 staff have completed Autism awareness training. One remaining staff will complete by 30/09/2022 5 core staff are assessed as requiring dementia training to support individual needs. 4 staff have completed and are in date. One remaining staff will complete by 30/09/2022. The PIC has also ensured that staff who provide support in this registered center have also completed this module.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The person in charge will ensure that HIQA is informed of all required notifications within the specified timeframes.	

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The person in charge and support staff promote and facilitate learning of practical and sensible money management skills supporting personal safety and independence.
All residents will be invited to participate in their reassessment tool on Managing My Money to identify those who may wish to manage their money to some degree. 28/10/2022
Each person will be invited and supported by support staff to identify a goal towards independence around safely managing their own finances. 31/12/2022

Each person who requires a facility for storage of valuable personal possessions and money will be provided same in their bedroom. 25/11/2022

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
General maintenance requests as submitted by PIC to facilities department are between 80% to 90% completed.
The following remedial works are scheduled for costing and schedule of works to be agreed in Q1 2023
• Walls which were cracked or scored with light to heavy damage to paint and plasterwork,
• Linoleum and carpet surfaces which were torn, worn or lifting
• Broken kitchen tiles,
• Damage around wall vents and electrical sockets,
• Peeling and worn surfaces on kitchen units, bathroom cabinets and bedroom wardrobes,
• Radiators and skirting boards requiring repainting,
• Cracks along some kitchen and bathroom ceilings.
In one location there is a plan to revisit project scope based on OT/DON review of client needs, layout and condition of property Q4 2022. This project will then be submitted to Property Management Committee for funding consideration.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: Housekeeping checklist based on IPC standards has been revised and all housekeepers will complete induction and refresher training by September 30th . Remedial works including painting and filling of cracks in ceilings and tiles required in this designated are scheduled to be submitted for costing and schedule of works to be agreed Q1 2023 This will include replacement and upgrade of surfaces to allow for effective cleaning.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Discontinuation of the use of door wedges will be addressed under fire safety practices agenda item for staff meetings and resident meetings. The provider has commissioned an external competent person (Technical Guidance Document; Part B Fire Safety) to inspect and report on each individual property (four). When available, any recommendations within these reports will form part of maintenance or remediation programs for each property based on the scope of works submission for funding.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Self-administration of Medication will be promoted across the registered centre. The Personal care support plan (How I take my medication section) will describe the supports needed to enable an individual to involve themselves safely in the administration of their own medication. Each individual within this registered centre will be offered the opportunity to participate in some or all of the administration of their own prescribed medication and this will be reviewed annually or more often if required.	
Regulation 5: Individual assessment	Substantially Compliant

and personal plan	

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
As a means of seeking to establish whether person centred planning is being done well and having a positive impact on people's lives staff will collaborate with the person to document and demonstrate evidence of their plans success or progress. Guidance documents on how to evaluate the effectiveness of personal plans have been reissued in this designated centre and form part of the PIC's role in supporting the upskilling and guiding staff on this role. This will be further addressed as a key agenda item at team meetings.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/12/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	28/10/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/03/2023

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/12/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/03/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	31/03/2023

	associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2022
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Substantially Compliant	Yellow	31/12/2022
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	05/08/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident	Substantially Compliant	Yellow	04/11/2022

	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).			
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	04/11/2022