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:	Goldfinch 2
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	11 November 2021
Centre ID:	OSV-0004751
Fieldwork ID:	MON-0034477

About the designated centre

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

Goldfinch 2 consists of two detached bungalows located near one another in a small town. The centre can provide full time residential care for a maximum of eight residents of both genders over the age of 18 with intellectual disabilities. Each bungalow can support four residents each and all residents have their own bedrooms some of which have en suite bathrooms. One bungalow also has a kitchen, a sitting room, a utility room and a staff office while the other bungalow has a kitchen/dining area. Residents are supported by the person in charge, nursing staff and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 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
Thursday 11 November 2021	10:00hrs to 18:35hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Residents were being supported to be part of the local community while interactions between residents and staff were generally seen to be respectful. The size of one house of this centre was inadequate to support the needs of all residents living there and to provide sufficient storage.

This designated centre was made up of two houses located in close proximity to one another. On arriving at the first house, the inspector observed a garden bench partially obstructing a pathway along the side of the house that lead to the fire assembly point at the front of the house. Upon entering this house the inspector was directed to sign in and to check his temperature. Three residents were living in this house and shortly after the inspection started they left with the three staff members present to go for a walk in the town where this centre was situated.

While there residents were gone, the inspector reviewed the house where they lived. Since this house was previously visited during a HIQA inspection in April 2021, it was seen that one room that was once primarily used as a staff office, had been converted to provide a small sitting room area although a staff workstation remained there. The residents' bedrooms were seen to be spacious, well maintained and personalised with photos. However, despite this it was clear that there was a lack of overall space in this house both in terms of storage and to ensure that the needs of all residents, who were wheelchair users, were appropriately met.

For example, the house had a central kitchen/dining area which was small given the numbers of staff and residents that could be present in this area while there was a number of marks from residents' wheelchairs on doors, doorframes and walls. In addition, it was noted that bathrooms in the house, including residents' en suite bathrooms were being used for storage purposes. In one such en suite bathroom it was seen that a commode and a chair were stored there. To access the toilet in this bathroom, the chair first had to be moved. In another en suite bathroom the inspector noted that some tiles surrounding a showering unit were missing.

The three residents living in this house returned shortly after. All three residents were met by the inspector when he was present in this house. None of the residents' meaningfully engaged with the inspector although it was seen that one resident was smiling when the inspector met them. Staff members on duty were seen to interact in a respectful and warm manner with residents for the brief period the inspector was in this house. For example, upon leaving, one staff member was supporting a resident with a meal. This was being done at eye level in an unhurried fashion.

As the inspector was leaving this house, he again noticed that the same garden bench as seen earlier was partially obstructing a pathway that lead to the house's fire assembly point. While there were other means to get to this fire assembly, the location of this bench as observed by the inspector did have the potential to impede

a fire evacuation route from the house. This was highlighted to the person in charge during the inspection who later indicated that this bench had been moved but there was no explanation given as to why this bench was placed where it was when observed by the inspector.

After leaving the first house, the inspector made the very short walk to the second house. Four residents were living in this house, three of whom were preparing to go out for a walk as the inspector arrived. The inspector went to perform hand hygiene using a hand gel dispenser at the front door but it was not initially working when the inspector tried to use it. This was highlighted to a staff member present who quickly replaced it. After the three residents went on their walk, the inspector met the fourth resident as they were sat at the kitchen table. It was noted that this resident appeared happy and appeared to enjoy a particular table top activity that was given to them by a staff member.

Overall, the second house was observed to be nicely maintained, furnished and decorated with each resident having their own bedroom which had ample storage for their personal belongings. It was also seen that this house was provided with fire safety systems that included a fire alarm, emergency lighting, fire extinguishers, fire blankets and fire doors. Such doors help prevent the spread of fire and smoke and provide for a protected evacuation route if needed. However, shortly after the inspector's arrival he noted that a fire door to the utility room, which was clearly marked as a fire door that should be kept closed, was wedged open. Keeping the door open in this way made it completely ineffective to prevent the spread of fire and smoke from the utility room were a fire to commence there. This was also highlighted to the person in charge who promptly removed this and informed the inspector that the door wedge had been disposed of.

The inspector spent the majority of this inspection in the second house as it had not been visited during the April 2021 inspection. It was clear that there was a focus on providing the residents with a homelike setting. For example, some food for residents to eat was prepared in the house while a red velvet cake was baked during the day which resulted in a nice smell for part of the inspection. Efforts had been made to involve residents in this baking and, as was also noted with residents in the first house, residents were being supported to be present in the community such as by going for walks in the town, going to get coffee and attending mass. Other activities such as pet therapy, reflexology and swimming was also supported while it was noted that the designated centre was shortly to receive a second vehicle which it was hoped would result in residents participating in more activities.

When the three residents in the second house returned from their initial walk, residents spent much of the afternoon relaxing in the house with staff members present engaging very pleasantly with them. Later on in the inspection, staff were preparing some of the residents to go out for a drive. During this period the inspector overheard one staff member say to a resident "come on now, we'll go for a drive". The resident did not initially respond to this with the same statement made to the resident a further three times before they reacted and indicated that they were going. The resident was not offered any alternative activity during this exchange. Based on a specific speech and language therapy (SLT) plan seen for the

resident, this was not the way this resident was to be supported to come to a decision on the activities that they did.

It was overheard though that another resident indicated that they did not want to go on this drive and this decision was respected. Overall, throughout the inspector's time in this house it was seen that the four residents appeared comfortable in the presence of the staff members on duty. A recent provider unannounced visit report had made similar observations. The four residents living in this house did not directly engage with the inspector but did appear content. As the inspector was leaving this house and finishing the inspection, it was seen that three of the residents were sat in the sitting together watching a movie.

In summary, efforts were being made to provide residents with homily environment to live in and to support them to be part of the community. Staff generally interacted with residents in pleasant, warm and respectful manner but one interaction was overheard where a resident was not offered a choice on the activity they did in the manner that had been recommended. One of the houses residents lived in lack space.

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

Capacity and capability

While active efforts were being made to support residents, a number of actions from the previous HIQA inspection had not been addressed while further actions were identified on this inspection. This suggested that the monitoring systems in operation were not identifying issues.

This designated centre had last been inspected by HIQA in April 2021 where only one house of the centre was visited. During that inspection it was found that certain areas such as residents' personal plans, the premises provided and staffing were in need of improvement. Following that inspection the provider submitted a compliance plan response outlining the actions they would take to come into compliance. To follow up on these actions and to ensure that the second house of the centre was visited, a decision was made to carry out the current inspection of the centre.

Since the April 2021 inspection it was found that the provider had made improvements in some areas such as personal planning while also making efforts to address other areas such as creating a small sitting room in one house. Despite these efforts, a number of actions that had been highlighted for improvement previously remained in need of improvement. This was particularly relevant with regard to space available in one house of the centre as already discussed elsewhere in this report. During this inspection it was indicated that a recent environmental

assessment had found that the space was not suited to meet the needs of all residents. It was noted that the provider had explored alternative options related to this and was giving this matter ongoing consideration.

Another recurrent area that required improvement related to aspects of staffing. The previous inspection found that the staff rosters in place did not indicate in which of the centre's two houses that individual staff had worked in, nursing staff was not being provided in line with the centre's statement of purpose and that a high volume of staff had worked in the centre which impacted staffing continuity. The exact same areas were again found to be in need of improvement on this inspection. The inspector was informed that rosters would soon be changed although in the compliance plan response for the April 2021 inspection, the provider had indicated that separate rosters for each individual house would be created by 28 May 2021.

It was particularly noticeable on this inspection that a high volume of different staff continued to work in this centre. Maintaining of continuity of consistent staff is important to ensure that there is a consistency of care and support. However from reviewing the rosters provided, the inspector counted a total of 56 different staff members who had worked in this designated centre since the beginning of June 2021. While it was acknowledged that issues related to the COVID-19 pandemic contributed to such a number, the overall number of different individual staff working in the centre did not provide assurance that consistent care and support was being provided. This was particularly evident regarding the communication supports for residents.

It was clear that those involved in the management of this centre were acutely aware of issues relating to the premises and staffing. However, despite the efforts that had been made, based on the findings of this inspection, the inspector could say that these matters had been satisfactorily addressed since April 2021. In addition, this inspection also found a number of other regulatory actions in areas such as fire safety, medicines and residents' communication supports. Such matters had not been identified by the provider's own monitoring systems.

Regulation 15: Staffing

Nursing staff was not consistently provided in accordance with the designated centre's statement of purpose. A high number of different staff had worked in the centre. Actual rosters worked were not being properly maintained. The exact same areas for improvement were found on the previous inspection of this centre.

Judgment: Not compliant

Regulation 23: Governance and management

Areas for improvement that were identified during the April 2021 inspection such as premises and staffing had not been sufficiently addressed. A number of further regulatory actions were found during the current inspection which indicated that the provider's monitoring systems were not effective.

Judgment: Not compliant

Quality and safety

Improvements had been made regarding residents' personal plans. However, SLT therapy plans for residents were not being implemented which was limiting residents' ability to communicate, express their choice and improve their understanding.

The April 2021 inspection of this centre found that reviews of some person-centred plans which involved participation from residents and their representatives were not being carried out in a timely manner. On the current inspection it was seen that a process of person-centred planning had been followed for residents to ensure that they were involved in their personal plans and so that priority targets could be identified for residents. Such targets included increased community activities and family visits. A system was in place to review such targets and there were indications that progress was being made towards these.

While this was a positive development it was clear from this inspection that some residents were not being adequately supported around their communication. In one of the houses visited by the inspector it was seen that each resident had a detailed SLT therapy plan from October 2020. From reading these plans it was clear that they were intended to improve residents' communication ability, increase their understanding and boost their engagement in decision making. The plans also outlined specific ways to communicate with residents which included the use of a choice board and communication apps on a tablet device for one resident and the use of objects of reference and Lamh signs (a means of communicating by hands) for other residents. Particular emphasis was placed on using such communication methods routinely and it was seen that a clearly marked box was available in this house with objects of reference contained within it.

However, from the evidence gathered during inspection, these SLT therapy plans were not being implemented. For example, when the inspector pointed out the box with the objects of reference to one staff member, he was informed by this staff member that they had not used these and had never seen any other staff using them. The inspector was also informed that a particular resident did not have a choice board and that there was no tablet device in the house that an communication app could be used on. In addition, as highlighted earlier 56 different staff had worked in this centre since June 2021 but from records provide only five staff members had completed training in Lamh with all of these five indicated as

being relief staff rather than staff who were intended to work permanently in the centre. It was noticeable when reading the SLT therapy plans that only two staff members signed these plans to indicate that they had read them.

The same impacted residents also had separate communication passports in place, some of which had been reviewed during 2021. The inspector read a sample of these passports and noted that they did not take into account the contents of the SLT therapy plans. As these plans were not being implemented, residents were not being assisted and supported to improve their communication. It was also noted that the same plans outlined ways in which residents were to be given a choice on activities that they did so that they could make their own decisions in this area. Based on an observation of the inspector's regarding an interaction between a resident and a staff member in one house, this resident was not being offered a choice in the manner outlined in their SLT therapy plan.

While in the same house the inspector had an opportunity to review some of the practices related to medicines. As part of this the storage space for medicines was reviewed. This consisted mostly of a main locked storage press which as seen to be neatly organised. A specific fridge for medicines was also available although at the time of inspection it was seen that this was unlocked. When looking into both the storage press and the fridge, the inspector saw some medicines which were either past their expiry date or should have been disposed of mixed in with other medicines that were in date and in use despite a specific box being available for medicines that had to be returned. For example, in the storage press there was a medicine with an expiry date of October 2018 while in the fridge one medicine was still present despite the medicine having first been used in March 2021. According to the instructions for this medicine it should have been disposed of 28 days after its first use.

The inspector reviewed documentation related to residents' medicines and from the sample of records reviewed, it appeared as though residents were getting their prescribed medicines at the prescribed time and in the correct form. The medicines documents reviewed were generally of a good standard although the inspector did note that some incorrectly stated residents' addresses. Some documentation relating to infection prevention and control practices were also reviewed during this inspection. This included visitors' logs which are important for contact tracing. It was noted that while these were in place some visitors to both houses of the centre did not always sign out. Records of twice daily temperature checks for staff and residents were also reviewed although for one resident some entries were seen where it was indicated that their temperature were being checked once a day. Staff were observed to be wearing face masks throughout this inspection and were also seen carrying out cleaning in both house. It was observed though that some improvement was required around hand hygiene practices.

Regulation 10: Communication

Residents' SLT therapy plans, which were intended to improve residents' communication ability, increase their understanding and boost their engagement in decision making, were not being implemented.

Judgment: Not compliant

Regulation 17: Premises

One house of this was not suited to the needs of all residents living particularly given the limited space that was present in the house. This was also impacting storage in this house. A numbers of walls, doors and doorframes in this house were also observed to be marked while some tiles were missing around a showering unit.

Judgment: Not compliant

Regulation 27: Protection against infection

Cleaning was carried out regularly in both houses of the centre. Supplies of personal protective equipment (PPE), cleaning products and hand gels were available. Staff underwent relevant training in PPE and hand hygiene. Staff were wearing face masks throughout the inspection although some areas for improvement around hand hygiene practices were observed. Residents' and staff's temperature were generally checked twice a day although when reviewing records for one resident it was seen that there were days when their temperature was only recorded once. Visitors logs were maintained but there were times when visitors did not sign out. A COVID-19 contingency plan specific to this centre was in place although it was noted that it lacked specifics in some areas. It was noted though that the provider had an overall guidance document in place that included relevant information including on how outbreaks of COVID-19 were to be responded to.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While records provided indicated that all staff members had undergone fire safety training, during this inspection a fire door was observed to be wedged open while a potential evacuation route was seen to be partly obstructed.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Some medicines which were either out of date or should have been disposed off were still in the medication storage available in one house and storage amongst medicines that were in date. The medicines fridge was unlocked. Some medicines documentation gave residents' wrong addresses.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans in place which were informed by a person-centred planning process. Personal plans were subject to multidisciplinary review. Residents were supported to participate in the community which helped support their social needs.

Judgment: Compliant

Regulation 8: Protection

No safeguarding concerns were identified on this inspection. Records provided indicated all staff had received safeguarding training.

Judgment: Compliant

Regulation 9: Residents' rights

While residents were generally seen to be treated respectfully, one interaction between a resident and a staff member around an activity was not consistent with the recommended way the resident was to be offered choice about their activities. Residents' meetings were happening in both houses on a weekly basis but, as also noted during the April 2021 inspection, some meeting notes made reference to private medical appointments for some residents.

Judgment: Substantially 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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Goldfinch 2 OSV-0004751

Inspection ID: MON-0034477

Date of inspection: 11/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The planned roster is filled in as far as possible. However it is not always possible to fulfil the skill mix given unplanned leave and availability of nursing staff as well as having to comply with public health guidance in relation to the management of covid. • Included in the Statement of Purpose is a risk assessment that sets out the mitigation to a change in the skill mix. • Separate rosters for each individual house were created and commenced Pay Period commending on 21.11.2021. • Day Staffing has now been agreed and is in place after decongregation process has been finalized. • Night Staffing will be agreed by the year end. • Contingency plan for Covid 19 was updated on the 30.11.2021 to include redeployment of staff and process to be followed to ensure continuity of front line services. **The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.**	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • An internal audit completed by PIC in consultation with CNM1 and Staff Nurse on 24.11.2021 and 01.12.2021.	

• Out of date medication removed and returned to pharmacy as per policy. New fridge for medication has been ordered to replace existing fridge.
• Monthly medication audit will take place in future and the findings will be reviewed by the PIC.
• The planned roster is filled in as far as possible. However it is not always possible to fulfil the skill mix given unplanned leave and availability of nursing staff as well as having to comply with public health guidance in relation to the management of covid.
• Included in the Statement of Purpose is a risk assessment that sets out the mitigation to a change in the skill mix.
• All staff have reviewed and signed Communication folder put in place by SLT
• PIC has linked with SLT on 12.11.2021 to review communications passports to ensure they are in line with communication plans.
• Facilities Manager contacted by PIC on 18.11.2021, free swing closure ordered for laundry room door and will be installed on delivery. Wedge was removed on the day of inspection.
• Facilities Manager contacted on 12.11.2021 re update on garden shed for storage and repainting of one house.
• Tiles replace around showering unit on 12.11.2021.
• The mix of residents in one house is under review with MDT and family input. While it is acknowledged that the space available to the residents is inadequate following an environmental assessment there is agreement following MDT and family engagement that the new living circumstances for the resident has resulted in an improvement to his quality of life. Also there is no evidence of impact on other residents currently residing there.
• One resident's family attended MDT on the 12.11.2021 advocating that that their family member remains in the designated centre until a suitable alternative community placement becomes available as L708 quality of life has enhanced since transitioning to his new home.
• L708 will remain on the AMT list for 2022.
• A second bus has been sourced to support the needs of the house and is in place.
• Additional day service support for residents will commence in Q1 2022

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• PIC met with CNM1 and staff of designated centre on 17.11.2021 to discuss how staff are to support residents in relation to their communication.
• Objects of reference developed by the SLT were moved from office area on 12.11.2021 to kitchen for visibility and easy access by staff for residents.
• All staff have reviewed and signed Communication folder put in place by SLT.
• PIC has linked with SLT on 12.11.2021 to review communications passports to ensure they are in line with communication plans.
• Training for Lamh signs specific to Goldfinch 2 to be organized with SLT and rolled out

to all staff in Q1 2022.
• All residents now have access to Tablet device in Ashleigh House.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The mix of residents in one house is under review with MDT and family input. While it is acknowledged that the space available to the residents is inadequate following an environmental assessment there is agreement following MDT and family engagement that the new living circumstances for the resident has resulted in an iimprovement to his quality of life. Also there is no evidence of impact on other residents currently residing there.
• The resident will be placed on the waiting list for an alternative placement. A planned transfer will take place once new houses are built in Pallasgreen.
• Improvement in quality of lives of residents since the move is obvious and there is no evidence of impact on other residents currently residing there.
• Facilities Manager contacted on 12.11.2021 re update on garden shed for storage and repainting of one house.
• Tiles replace around showering unit on 12.11.2021.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• It was emphasized to staff on 17.11.2021 the importance of adhering to hand hygiene guidelines, jewellery not appropriate. Also the importance of maintaining hand gel was emphasized.
• PIC advised staff to ensure all residents temperatures are checked twice daily as per guidelines.
• Staff reminded to sign in and out. Also staff to remind visitors to sign in/out, to ensure accurate contract tracing if required.
• Contingency plan updated on 30.11.2021 to include more specific details in relation to the role of front line staff.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Facilities Manager contacted by PIC on 18.11.2021, free swing closure ordered for laundry room door and will be installed on delivery.
• Bench identified was removed on day of inspection 11.11.2021 .It was emphasized to staff on 17.11.2021, the courtyard bench was not to obstruct access to bungalow and it was to remain against wall.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• An internal audit completed by PIC in consultation with CNM1 and Staff Nurse on 24.11.2021 and 01.12.2021.
• Out of date medication removed and returned to pharmacy as per policy.
• Monthly medication audit will take place in future and the findings will be reviewed by the PIC.
• Documentation to reflect permanent move to Goldfinch 2 completed on kardex's.
• New medication fridge ordered on 26.11.2021, awaiting delivery.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Reviewed agenda item list issued to staff on 17.11.2021 for residents house meetings in the designated centre by PIC and staff advised not to make reference to private medical appointments for residents.
• All staff have reviewed and signed Communication folder put in place by SLT
• Objects of reference developed by SLT moved from office area on 12.11.2021 to kitchen for visibility and easy access by Staff for residents to support choice being offered for activities.

• PIC will follow up on the use of these communication tools, for supporting good communication and choice for the resident, as part of her oversight of this service.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	31/03/2022
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	17/11/2021
Regulation 10(3)(b)	The registered provider shall ensure that where required, residents are facilitated to access assistive technology and aids and appliances to	Not Compliant	Orange	17/11/2021

	promote their full capabilities.			
Regulation 10(3)(c)	The registered provider shall ensure that where required residents are supported to use assistive technology and aids and appliances.	Not Compliant	Orange	17/11/2021
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	31/01/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/01/2022
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	31/01/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and	Not Compliant	Orange	31/03/2024

	laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/01/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/01/2022
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	Substantially Compliant	Yellow	17/11/2021

	prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	17/11/2021
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	11/11/2021
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	24/11/2021
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable	Substantially Compliant	Yellow	24/11/2021

	practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	12/11/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and	Substantially Compliant	Yellow	17/11/2021

	personal care, professional consultations and personal information.			