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

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| Name of designated centre: | Brook House |
| Name of provider: | Stepping Stones Residential Care Limited |
| Address of centre: | Dublin 4 |
| Type of inspection: | Announced |
| Date of inspection: | 27 April 2022 |
| Centre ID: | OSV-0005419 |
| Fieldwork ID: | MON-0027795 |

## About the designated centre

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

The designated centre is based in a suburban area of South Dublin and is comprised of one detached three storey building. On the ground floor of the centre there is an entrance hallway, a living room, a utility room and toilet, a small medication room, and a large kitchen and dining room. On the first floor there are two resident bedrooms, a staff sleep-over room, a main bathroom, and a hot press. On the second floor there is a large resident bedroom. All resident bedrooms contain en-suite facilities. Externally, the centre provides a small enclosed garden space to the rear with an outdoor dining area and a staff office in an external building. The centre provides a residential support service to individuals with intellectual disabilities and the staff team is made up of a person in charge, a social care leader and a team of social care workers and carers.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 3 |

## 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 27 April 2022 | 09:35hrs to 15:30hrs | Erin Clarke | Support |

## What residents told us and what inspectors observed

The designated centre is based in a suburban area of South Dublin and is comprised of one detached three storey building. The centre is registered for a maximum of three residents with an intellectual disability. The inspector met with one resident during the course of the inspection, one resident declined to meet with the inspector, and a third resident was in hospital for a prolonged stay. Since the previous inspection, two new admissions into the centre had occurred. The inspector was informed that one resident found the initial transition period challenging, but staff had worked at developing a positive rapport with the resident and supporting the resident to realise their goal of living more independently. The inspector saw that key working sessions were taking place to support this goal by increasing the resident's skill set, for example, budgeting of finances and cooking.

A second resident who had recently moved into the house told the inspector they were happy and had enjoyed their day out with staff to buy personal items. From speaking to the person in charge, staff and the resident, it was clear that there were a number of positive outcomes for the resident that impacted all aspects of the resident's life including social, health and personal improvements. Throughout the day, the inspector observed staff interactions with the residents were kind and respectful through positive, mindful and caring engagements. Residents were observed to be comfortable in the company of staff, sharing laughs and speaking openly.

In addition to meeting residents and staff along with observing their interactions during this inspection, the inspector also reviewed documentation relating to the centre overall and individual residents. For example, the inspector read the records of complaints and compliments made. There was a complaints log in place with a record of any complaints. Any complaints made by residents or their advocates were addressed in a serious and timely manner by the person in charge or persons participating in management. There was a designated person to raise concerns with, and the complaints process was clear to residents and their representatives. A record of a compliment from a resident's family member was also read where they praised the support given to the resident since moving into the service.

Staff who spoke with the inspector were knowledgeable about residents' support needs, preferences and aspirations. The inspector reviewed the personal plans of a selection of residents. There was evidence of assessment by appropriate healthcare professionals and that the resultant personal plans had been reviewed with input from multidisciplinary professionals or that this was planned for the near future. The inspector found that residents' healthcare needs were well met.

As part of the announced inspection, questionnaires were sent to the centre for residents and families to complete if they wished. These questionnaires focused on a range of subjects, including general satisfaction with the service being delivered, bedroom accommodation, food and mealtime experience, arrangements for visitors

to the centre, personal rights, activities that residents engage in, staffing supports and complaints. One questionnaire had been posted directly to HIQA, and two were received during the inspection. The feedback in the questionnaires was very positive. Residents and their family representatives indicated that they were happy with the warmth and comfort levels in the designated centre. They also indicated they were happy with the choices available to them and with how their rights were respected. All three participants said they were happy with the support offered by the staff team and that they liked them. One family member said, " staff are very patient.." and "everything is led by the needs of the person".

Overall, a high level of compliance was found during this inspection, and improvements had been made in a number of areas since the previous inspection. Residents in this designated centre were being supported to enjoy a good quality of life in a very homelike environment. Supports was also being given to residents to increase their independence and to develop to their full potential. As discussed further in the report, some improvement was required relating to risk management, infection prevention and control measures and fire safety.

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 the service's quality and safety.

## Capacity and capability

The designated centre had last been inspected in September 2020. At the time of the inspection, the centre was without a named person in charge, and a significant number of non-compliances were identified under the capacity and capability regulations. Following that inspection, the provider submitted a compliance plan outlining how they would address the areas for improvement. During the current inspection, it was found that the provider had taken action to respond to the issues of concerns raised in the previous inspection. There was clear evidence that the identified actions were being implemented in practice. For example, the provider had ensured that a competent and capable person in charge was in place, and staff had been facilitated to attend training aligned with residents' needs.

The person in charge commenced their role in September 2020, and they had the necessary skills, experience and qualifications to perform the role. The person in charge worked closely with staff and residents and was based full-time in the centre. Throughout the inspection, the inspector had found the person in charge to be very familiar with residents' care and support needs and operations of the centre. The person in charge was supported in their role by a full-time team leader who was also based in this designated centre. This was in keeping with the centre's organisational structure as outlined in the designated centre's statement of purpose. This is an important governance document that should reflect the services provided to residents. Under the regulations, the statement of purpose must contain specific

information such as details of the services and facilities to be provided, the arrangements for complaints and the arrangements for respecting residents' privacy. Taking into account the overall findings of this inspection, residents were being provided with appropriate care and support in accordance with the centre's statement of purpose.

The inspector found there were strong monitoring systems in place to review the quality and safety of care and support provided to residents. The provider was complying with the requirement of the regulations to conduct an annual review of the quality and safety of the service and to undertake six-monthly unannounced audits of the centre. The report of the annual review for 2021 was reviewed by the inspector, who found it was of high quality and objectively assessed if the care and support provided was in accordance with relevant national standards as required by the regulations. If improvements were identified, a timebound action plan was implemented as a corrective action. In addition to these structured audits, the inspector found that the provider had additional systems for monitoring the quality and safety of the centre. The person in charge was responsible for conducting a number of local audits in order to address areas for improvement in a timely manner.

The staffing arrangements in place were found to be adequately supporting residents' assessed needs during this inspection. A continuity of staff was provided to support residents while planned, and actual staff rosters worked were maintained. Staff were also receiving formal supervision and since the previous HIQA inspection, they had also undergone specific training to support the behavioural and mental health needs of residents. The inspector reviewed a sample of staff files and found that they contained all of the required information, such as evidence of Garda Síochána (police) vetting and safeguarding of vulnerable adults training.

## Regulation 14: Persons in charge

A dedicated person in charge had been appointed in the designated centre. It was evident that this person held the necessary skills and qualifications to fulfil the role. They had experience of working in and managing services for people with disabilities. They were also found to be aware of their legal remit to the Regulations and were responsive to the inspection process.

Judgment: Compliant

## Regulation 15: Staffing

The inspector was satisfied that there were adequate staffing arrangements in place

to meet the needs of residents. Where required, residents were provided with one-to-one staff support. Staff rosters were being maintained in the designated centre which indicated that there was a core staff team in place to support residents.

The provider had obtained the information required in respect of staff under Schedule 2 of the regulations.

Judgment: Compliant

## Regulation 16: Training and staff development

A review of training records found that all staff had completed the training outlined as required by the registered provider. The person in charge and staff team had undertaken additional training in areas such as diabetes management, human rights and mental health.

The inspector found a strong system of supervision and developmental and supports for staff. Supervision meetings occurred every eight weeks, which included competency checks on medicines, complaints, restrictive practice and fire safety. In addition, all new staff had a detailed orientation to the centre and the residents as part of their induction. This induction included a walk through of the centre, a review of pertinent policies and procedures, discussions relating to residents' needs, social goals, positive behavioural supports, fire safety and guidelines on the use of personal protective equipment.

Staff who spoke with the inspectors were clear about their responsibility to report any concerns or allegations of abuse in order to keep the residents safe.

Judgment: Compliant

## Regulation 21: Records

All records and documentation reviewed on this inspection were found to be clear, accurate, safely secured and easy to retrieve.

Judgment: Compliant

## Regulation 23: Governance and management

There were effective governance, leadership and management arrangements to govern the centre, ensuring the provision of good quality care and safe service to

residents. The provider had appropriately addressed any issues from the centres previous inspection. The high levels of compliance found on inspection were reflective of a service that demonstrated a person-centred approach while embracing continuous improvement.

The inspector met with the person in charge and the regional manager during the inspection. The inspector discovered that the management team was competent and dedicated to the centre's ongoing development and improvement of services.

In addition to the annual review previously mentioned, the provider had ensured that a six-monthly audit of the centre were conducted in October 2021 and February 2022. Again this indicated a good level of compliance and covered areas such as complaints, restrictive practices, safeguarding and notifications while also providing for consultation with residents and staff.

The centre had developed a schedule of Audits for 2021. These included: environmental audits, medicine audits, fire safety, risk management, infection prevention control and personal care plan audits. The inspector found that were actions were required; these were completed and recorded on a quality improvement plan as appropriate.

Judgment: Compliant

## Regulation 24: Admissions and contract for the provision of services

The provider had an admissions policy and procedures in place and the criteria for admission was outlined in the centre's statement of purpose.

The provider had identified that they needed to review the admission pathway to ensure the admissions committee approved all admissions. Withstanding this, from the sample reviewed, residents' admissions to the centre followed a thorough process, and all other related procedures and checks had been completed. A transition, evaluation and support plan had been devised with the resident, circle of support and day service staff. There was documented evidence of ongoing consultation with the resident in conjunction with another provider who currently supports the resident with day services. The resident has been supported to visit the house and meet their peers on a number of occasions while adhering to the public health guidelines.

In addition, each resident had a contract of care which contained information in relation to care and support in the centre and the services provided.

Judgment: Compliant

## Regulation 31: Notification of incidents

The provider and person in charge had ensured that appropriate notifications and quarterly returns had been submitted to the Chief Inspector as required by the regulations. It was also noted that recent incidents in the centre were factored into the analyses of key risk assessments. Such incidents were recorded through a formal incident reporting system, which the inspector examined. Accidents and incidents were recorded as part of the effective risk management strategy to ensure that risks are assessed to account for new developments.

Judgment: Compliant

## Regulation 34: Complaints procedure

The registered provider had established and implemented effective systems to address and resolve issues raised by residents or their representatives. Systems were in place, including access to an advocacy service, to ensure residents had access to information which would support and encourage them express any concerns they may have.

Complaints reviewed by the inspector were found to have been appropriately followed up on by the registered provider.

Judgment: Compliant

## Quality and safety

The inspector found that the improved governance and management arrangements in this centre helped ensure that the quality and safety of care delivered to residents was regularly assessed and reviewed in order to achieve and maintain consistently high standards. Some improvement was required relating to risk management, infection prevention and control measures and fire safety.

In the company of the person in charge, the inspector did a full walk through of the centre. The premises was found to be very clean, tastefully furnished, and well-maintained throughout. Each resident had their own bedroom, which was decorated and equipped according to their personal preferences. There was sufficient storage space as well as an adequate quantity of bathrooms and showers. Where modifications or assistive aids were required, these had been assessed and implemented by an appropriate healthcare professional for resident use.

The provider had ensured that there were fire safety management systems in place in the centre, and clear arrangements were in place in the event of a fire. Residents had Personal Emergency Evacuation Plans (PEEPs), which included guidance for staff on the supports each resident required to evacuate by day and by night. Fire drills were being carried out regularly including to reflect times when staffing levels would be at their lowest. The inspector found that the fire fighting equipment and fire alarm systems were appropriately serviced and checked for the most part, and that there were satisfactory systems in place for the prevention and detection of fire. One fire blanket in the kitchen had not been serviced within the stated time frame as it had not formed part of the external contractor's checks.

The inspector found overall, effective management of risks in the centre, with evidence of staff implementing the provider's risk management policies and procedures for example, the recording and logging of accidents and incidents through the provider's formal incident reporting system. In addition, a risk register was maintained and updated as required. The register provided a good overview of all managed risks in the centre. Some risks had been identified as high risk. Where these were identified, they were subject to ongoing close review and monitoring. Where required, serious incident reviews had occurred by senior management, demonstrating good governance and monitoring of risks that occurred in the centre. The inspector also acknowledged the person in charge and staff's person-centred management of some personal risks for residents, demonstrating a practical and person-centred approach to managing risks for residents. While walking around the centre, the inspector identified two risks that had not been assessed as part of the risk assessment process. A medicines refrigerator was accessible to residents due to not having a locking mechanism. Risk assessments regarding the use of sharps and prevention of needle stick injuries also, had not been completed in line with best practice.

Residents had individual personal plans, with residents having been involved in the development of these plans through a person-centred planning process. Where residents opted not to part take in the planning process, this was respected and documented. The inspector reviewed a sample of such plans, and it was noted that they outlined the supports they required in various areas, including how to support residents with managing any behaviours of concern. This was supported by the presence of specific positive behaviour support plans in place. The behavioural support plans were person-centred in the description of the resident with a focus on their need as opposed to an issue. These plans contained proactive strategies with a rights-focused approach to guide staff. Due to the complex nature of some of the residents' support needs, a consistent and professional approach to behavioural support was required and this was found be provided and continuously reviewed in this service.

Healthcare plans reviewed were of a high standard, and residents had continuous access to allied health professionals in line with their needs. Residents with increased healthcare needs were provided for in terms of regular reviews and care planning updates. For example, residents who required access to psychology, general practitioner and diabetes specialists were facilitated to attend appointments. In addition, the person in charge had scheduled diabetes management training for

all staff in advance of the admission of the new resident in February 2022. The health action plans reviewed were comprehensive and explored a holistic approach to promoting good health, such as trust building, developing supports and providing education plans.

The inspector reviewed the measures being made to protect residents from COVID-19 and other healthcare-acquired infections. During the inspection, it was seen that infection prevention and control measures were being followed, including regular cleaning, staff training and the use of personal protective equipment (PPE). The inspector found that the centre was visibly clean, and cleaning checklists were dated and signed for cleaning completed. A sharps box was kept for the safe disposal of single-use needles, a recent procedure in the centre. When reviewing the provider's policy for infection prevention and control, it was noted that the policy did not contain guidance on the safe management of sharps or inoculation injuries and required updating to provide sufficient guidance to staff.

A contingency plan was also provided for this centre which had been recently reviewed in March 2022, and provided guidance for how to respond in the event that COVID-19 related concerns arose. The inspector did note some inconsistencies between the guidance provided in the contingency plan, Health Protection Surveillance Centre guidance and the actions taken during the inspection for a suspected case of COVID-19. The inspector brought this inconsistency to the attention of the person in charge immediately so it could be rectified.

## Regulation 17: Premises

The house visited by the inspector was seen to be generally well-maintained, well-furnished, clean and homelike. The premises was appropriate to the number and needs of the residents and was in line with the centre's statement of purpose.

Judgment: Compliant

## Regulation 26: Risk management procedures

The centre had implemented systems to ensure that any potential or actual risks were assessed and mitigated where possible.
Clear records were maintained of any accidents or incidents in the centre, and the person in charge completed a review of these and subsequently completed risk assessments and implemented risk measures when necessary. Where incidents required further review with a specialist, the person in charge was making relevant referrals.

Service users all had individual risk assessments in place. The centre also had a risk register which outlined general potential risks such as slips, trips and falls,

medication errors and risks associated with COVID-19.

The inspector identified two areas of risk that required review in line with the providers risk management process.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

The provider had policies and procedures in place in relation to infection prevention and control. Staff had completed several IPC training courses including hand hygiene, infection control and PPE training. The provider had developed and adapted existing policies and procedures to guide staff practice during the COVID-19 pandemic. Information was readily available in the centre for residents and staff in relation to COVID-19.

The inspector observed that the majority of infection prevention and control practices were being followed in this centre, including regular cleaning, staff training and the use of PPE. During the inspection, it was noted that a suspected case of COVID-19 had not been managed in line with published guidance from the Health Protection Surveillance Centre. The infection prevention and control policy dated December 2021 also required review to ensure it adequately addressed and provided guidance relating to IPC matters in the centre.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

There were satisfactory systems in place for the prevention and detection of fire. All staff had received suitable training in fire prevention and emergency procedures and overall, firefighting equipment and fire alarm systems were appropriately serviced and checked.

However, a review of the current fire equipment servicing system was required to ensure it included all additional firefighting equipment that had been purchased from outside the centre's current external fire safety company.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

The person in charge had ensured that all residents had an assessment of need and a personal plan in place that was subject to regular review. Assessments of need clearly identified levels of support required.

Residents were supported to make choices and decisions with regard to activities and personal goals. There was a key working system in place, and key workers supported residents to achieve set personal social goals in place, which were agreed upon at residents' personal planning meetings. The rights of residents to opt-out of the formal goal planning process was respected while efforts were made for the resident to fulfil their potential through other methods.

Judgment: Compliant

## Regulation 6: Health care

The person in charge had ensured that residents' healthcare needs were assessed on a regular basis and guidance was available to support staff in caring for the healthcare needs of these residents. Residents also had access to a wide variety of healthcare professionals, as required.

A sample of personal plans reviewed contained information relating to residents' medical histories along with records of assessments made by healthcare professionals. The inspector saw examples of clear guidance provided to direct care relating to residents' healthcare needs.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Restrictive practices were used in accordance with national policy and evidence based practice and were subject to regular review. Residents were supported to manage their behaviours and had access to a full time behavioural therapist within the service. Service users had positive behavioural support plans in place when required which were subject to regular review

Staff had a good understanding of behavioural support plans which were in place and restrictive practices which were implemented in the centre were kept under regular review to ensure that the least restrictive practice was implemented at all times.

Any restrictive practices in use, were used in accordance with national policy and evidence based practice and were subject to regular review.

Judgment: Compliant

## Regulation 9: Residents' rights

The inspector observed that residents' rights were promoted. Residents were consulted in the running of the centre and in decision making through monthly resident meetings and through the annual report consultation process.

Personal care plans and intimate care plans demonstrated that residents were treated with dignity and respect and promoted person-centre care. The inspector observed communication and interactions between staff and residents and found it to be caring and respectful at all times.

The person in charge also assured that staff were aware of the standards and relevant guidance issued by statutory and professional bodies to support residents rights. Staff had completed the e-learning module by HIQA, 'Human Rights-based Approach in Health and Social Care Services', to help staff working in health and social care services apply a human rights-based approach to care and support for people using services.

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 | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Brook House OSV-0005419

## Inspection ID: MON-0027795

## Date of inspection: 27/04/2022

**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 26: Risk management procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
PIC has submitted a draft copy of the SHARPS Policy, and this is awaiting final review and sign off from senior management team. The Policy addresses the risks associated with using Sharps, eliminating the unnecessary use of sharps and identifies controls to be in place to minimise risks of using Sharps.
Completion Date: 30.06.2022

SHARPS Risk Assessment is now in place. The appropriate controls have been identified to minimise the risks taking into consideration any incidents, near misses, feedback from staff and observations of Team Leader and PIC. This risk assessment will be reviewed and evaluated money in line with the Centre's integrated risk management policy.
Completed: 30.04.2022

PIC developed a Shared Learning document for Staff to address immediate safety precautions staff can adhere to in the safe administration of prescribed insulin to compliment the previous SHARPS Learning issued to staff on 17.03.22.
Completed: 17.03.2022

A separate storage box for storing medication that is due for return to Pharmacy is ordered and due to be installed by maintenance by 20th of June 2022. This box will be affixed to the wall to minimise the risk of movement of the medication for returns until enroute to the pharmacy.
Completed: 20.06.2022

A lock was installed on the medication fridge to ensure security and safety of storage of medication requiring refrigeration. Staff always have access to the key which is stored with the medication keys secured by staff on duty.
Completed: 07.06.2022

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| Regulation 27: Protection against infection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Infection Prevention Control Policy was updated and signed off for circulation on 8th of April 2022 and this version of the policy now replaces all previous versions that were on file. Staff have read and signed off on the circulated updated policy.

Covid 19 Response Plan was updated and circulated on the 20th of January and signed off by staff and placed in the policy folder. This Policy is now in the Covid -19 Information Folder and all previous Covid 19 Response Plan information is archived and removed from the current material accessible to staff and residents. PIC ensures latest guidance from HSE/HSPC/AMRIC is printed and placed in the Covid 19 Folder.

PIC has updated the Covid 19 Contingency Plan to be fully reflective of the latest guidance for staff in correctly managing signs and symptoms of Covid 19 and outlines in detail responsibilities for actions in case of suspected/confirmed cases of covid 19 for either residents or staff. This Contingency Plan is updated monthly or more frequently as required.
Completed: 09.05.2022

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| Regulation 28: Fire precautions | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
External Fire Safety Company attended Brook House on the 5th of May 2022 and did a safety Check to ensure all firefighting equipment was fully serviced and up to date and ready for safe use as required.
Completed: 05.05.2022

Regional Manager in communication with the external Fire Company on 27th of April 2022 who reverted back to Regional Manger and Registered Provider to assure of the safety of the fire safety system installed.
Completed: 27.04.2022

## 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 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. | Substantially Compliant | Yellow | 30/06/2022 |
| 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 prevention and control of healthcare associated infections | Substantially Compliant | Yellow | 09/05/2022 |

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| | published by the Authority. | | | |
| Regulation 28(2)(b)(iii) | The registered provider shall make adequate arrangements for testing fire equipment. | Substantially Compliant | Yellow | 05/05/2022 |