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:	Hazel Lodge
Name of provider:	Terra Glen Residential Care Services Limited
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	28 September 2023
Centre ID:	OSV-0008104
Fieldwork ID:	MON-0039997

About the designated centre

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

This centre comprises a large detached property in a rural area in County Wexford. The centre is registered for a maximum of three individuals over the age of 18 years and is currently home to two residents. The centre comprises a kitchen and dining area, sitting room, staff office and three registered en-suite bedrooms with an additional bedroom for staff use. There is a large garden running around the property currently set to lawn with a patio area accessed from the kitchen. The centre is staffed at all times when a resident is present and the staff team is made up of a person in charge, service manager, two shift leads and a team of social care workers. The provider states that their aim is to provide a home from home while supporting all individuals who live in the centre to reach their full potential.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Thursday 28 September 2023	10:00hrs to 17:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This centre was most recently inspected in March 2023 following receipt of solicited information of concern. That inspection found significant non-compliance with the regulations. Following that inspection the provider was requested to submit a time bound compliance plan to the Chief Inspector of Social Services that outlined measures they would take to come into compliance with the Regulations. This inspection was completed to review progress/regress against this provider submitted compliance plan.

The inspector found that there had been a change to the local management team for the centre since the last inspection. The provider had worked to ensure that the two residents who live in this centre were safe and provided with good quality care and support. The inspector found that there had been improvement in compliance in a number of Regulations reviewed. Some further improvement was still required in staff training, infection prevention and control and in the oversight and support systems in place to safeguard resident finances.

This centre is registered for a maximum of three residents and is currently home to two individuals. The inspector had the opportunity to meet with one of the individuals who live in the centre with the other resident deciding to complete tasks in the community on finishing the day in their training and support programme. The inspector acknowledges the supports in place to facilitate this resident to attend a regular day programme and to engage in their community as this had been a key goal stated by the resident at the last inspection.

Both residents were attending their individual day services when the inspector arrived. Their days included social opportunities, educational modules such as literacy or computer skills in addition to skills training such as woodworking. For both residents there had been a change in how they spent their day since the last inspection. The staff team had advocated for one resident to change to a new day service provider and had supported their transition from one service to another. The resident told the inspector later in the day that this move had been a good for them and they were 'very happy'. The other resident at the point of the last inspection had spent their day in the centre and did not engage in any external structured activity. The staff team had supported them to find a youth training programme that supported their assessed needs and they had recently started there. This was reported to be a positive change for the resident with them positively engaged in a number of new activities.

This centre is a large detached two storey house in a rural setting but in close proximity to a number of towns in Co. Wexford. The house contains spacious communal and shared areas in addition to large private spaces for both residents. One resident told the inspector that they liked their room and moving their furniture around however, they also liked some of the other bedrooms in the house and they showed the inspector one room they liked to the front of the house. The resident

met with the inspector to chat in the kitchen and told them that they would change nothing in their home or with the service as they were really happy and liked all the staff. This resident was observed later sitting with staff who were completing paperwork and asking questions about the processes the staff completed. The resident also told the inspector that they loved dancing and went to line dancing classes which were important to them. Both residents took pride in their home and had been involved in painting garden furniture, keeping their personal areas clean and engaged in tasks such as the weekly shop and their laundry.

The staff team presented as knowledgeable in relation to the individual needs of the residents. The inspector had the opportunity to talk with the staff over the course of the inspection and observed them engaging with one resident later in the day. Staff reported that they had begun to complete human rights training with some having completed all modules and others just starting. The staff were able to outline the different supports that the residents required. Staff discussed the challenge there had been in developing personalised routines for the residents and in supporting them in managing behaviours that challenge. They outlined the different supports required both by day and at night for the residents and how different supports had been developed for each resident providing support in areas such as administration of medication that supported their learning and independence.

The quality of care and support provided to the residents was observed to be good with overall improvement in levels of compliance with the Regulations however, the inspector found some areas that required review and improvement. For example, the management of personal possessions, infection prevention and control and staff training and support. In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

This inspection was facilitated by the person in charge of the centre and the centre service manager. There had been a change in the local management team since the previous inspection of the centre. The inspector found that there was an improved overall standard of care provided to residents with some further improvements required as already stated, which will be discussed under the relevant Regulations below.

The person in charge who facilitated the inspection was found to have a good knowledge of the individual care needs for the residents in this centre, including where specialist medical services or external agencies were involved in the oversight and review of care. The person in charge was in a full-time role and they held responsibility for the day-to-day operation and oversight of care in this and one

other centre operated by the provider. They were supported in their role by a service manager for this centre who also had detailed knowledge of residents' needs and it was clear that the aim of both managers was to promote the welfare and well-being of the residents who lived in this centre.

Staff who met with the inspector had a good understanding of residents' needs and also of the procedures which promoted their safety, welfare and well-being. Staff members outlined the prescribed response in regards to the reporting mechanisms for any areas of concern which they may have. In addition, staff training records were reviewed which indicated that for the most part staff were up-to-date with their training needs and they had attended training in areas such as medicines management, fire safety and also behaviours of concern.

Regulation 15: Staffing

The provider had ensured that the staffing compliment of the centre was in line with the assessed needs of the residents who lived here. The numbers of staff had been adjusted and changes made in the roster such as presence of waking staff instead of sleeping staff at night in response to either significant incidents or changes to the assessed needs of residents. The staffing levels were found to be reviewed on an ongoing basis and were reflective of resident need. Currently within the centre there was a full staff team with no vacancies.

The inspector reviewed the current and planned rosters in addition to a sample of previous rosters and found that they were well maintained and reflective of the actual staff in the centre. The person in charge was available as required but had a minimum of one day a week that they were present in the centre. The residents were supported by one waking staff by night and by staff in a 1:1 capacity by day up to 23:00. The person in charge had access to a team of consistent relief staff that were used to cover planned leave or absence.

The staff team had access to a member of the management team for support at all times and outside of working hours information on who to call was available via an on-call roster. The inspector reviewed a sample of staff personnel files and found that they contained all information and documents as required in Schedule 2. Where agency staff had been used on the roster there was sample documentation available and evidence of meetings between the provider and the agency to ensure that the required documentation was available when needed.

Judgment: Compliant

Regulation 16: Training and staff development

The provider and person in charge ensured that all staff were facilitated to attend training and refresher training as required. The provider had, since the last inspection, developed a system of oversight to ensure that training was monitored and scheduled when required. There was evidence that for the most part staff had completed training that was mandatory, in addition to training that was specific to the assessed needs of the residents. For staff that were new to the centre however, it was unclear whether they had completed mandatory training including safeguarding or fire safety prior to being added to the centre roster. The monitoring and timing of training for new staff required review.

There was a system of formal supervision and support in place and the person in charge and service manager had a schedule to ensure all staff were supported as outlined in the provider's policy going forward. However, supervision and formal support had not been carried out consistently up to the date of the inspection in line with the provider's policy. There was evidence however, of some informal supervision and supplemental (following an incident) supervision taking place. Staff reported that they felt supported and that they knew who to speak with should they have a concern. Where staff were new to the centre and to the provider there was a record maintained of an induction and probation pathway.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had ensured that there was a management team in place with clear lines of authority and accountability. The person in charge was employed in a full-time capacity and had responsibility for this and one other centre operated by the provider. They were supported in the centre by a service manager who in turn was supported by two staff members who held the position of shift lead. In addition the person in charge was supported in their role by a senior manager for the provider who held the role of person participating in management for this centre. They provided support for the local management team and there was evidence that they were present in the centre on a regular basis.

The service manager and the person in charge met on a regular basis and there were regular formal support meetings held face-to-face with written action plans arising from these as part of the oversight systems in place. There was evidence of regular audits completed and action plans that arose from these with clear records of progress towards meeting these actions recorded. Weekly governance reports were completed by the service manager and reviewed by the person in charge they

were also reviewed and responded to by the person participating in management.

The provider had systems for their oversight which included an annual review and six-monthly unannounced visits as required by the Regulation in addition to senior manager audits and spot checks and reviews.

There were staff meetings occurring with minutes available which allowed for systems of communication within the staff team. In addition managers meetings were held to review matters that pertained to centres operated by the provider and to share learning across centres.

Following incidents or accidents in the centre there was review of these completed by the provider's 'significant event review group' (SERG) and evidence that changes to practice or actions arising from these was followed through.

Judgment: Compliant

Regulation 3: Statement of purpose

A statement of purpose is an important governance document that outlines the model of care and support that is provided in the designated centre. It reflects the day-to-day operation of the centre and promotes transparency by describing the centre aims and objectives alongside the service provided.

The inspector reviewed the statement of purpose for this centre and found that while it had been reviewed to reflect the new management structures it required further review to accurately reflect the staffing complement. The person in charge reviewed and amended this document on the day of the inspection and an up-to-date version containing all information as required in Schedule 1 was in place in the centre prior to the end of the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider and person in charge had ensured that incidents and accidents had been notified to the Chief Inspector of Social Services as required by this Regulation. The inspector reviewed the records of incidents in the centre and found that all were recorded and reviewed by both the person in charge and person participating in management for the centre and where they required notification these had been returned within the time frames as required

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had ensured that they had all policies as required by the Regulation in place to guide practice in the centre. The current policies were made available to staff and were reviewed by the provider as required. Procedures in place to guide the safe and effective delivery of care and support were reflective of guidance in the provider's policies.

Judgment: Compliant

Quality and safety

The inspector found that residents were supported to develop their independence skills and to enjoy a range of activities. The service promoted their welfare and well-being. The residents from observation and report were happy living in the centre and were supported by a staff team who had a kind approach in the provision of care. The inspector observed that the person in charge, service manager and staff team responded respectfully to residents and were caring and familiar with their individual needs.

Residents were protected by the polices, procedures and practices in place in relation to safeguarding and protection in the centre. As outlined under Regulation 12 below, improvements were required in the management of financial vulnerabilities. Staff had for the most part completed training and were found to be knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse. Where residents presented with behaviours that challenge there was evidence of systems in place to support them in managing these. Staff spoke of creating an environment or using communication strategies that reduced the likelihood of behaviours that challenge occurring.

Residents were actively supported and encouraged to connect with their family and friends and to take part in activities in their local community. They were being supported to be independent and to be aware of their rights. They were also supported to access information on how to keep themselves safe and well.

Regulation 12: Personal possessions

The provider and person in charge had ensured that the residents had access to

their personal items and that photographs or personal possessions were available to them throughout their home. The house presented as personal to the residents who lived there with, for example, a table football game in the living room or Halloween decorations in the sun-room. There was a comprehensive and current asset register for residents that detailed the items that belonged to them.

However, significant improvement was required in financial oversight systems and in practices to safeguard resident finances. While there were some day-to-day oversight practices of cash transactions and cash balance checks these were not supplemented with any further oversight or auditing systems such as statement reconciliations. Where a resident was assessed for example as having capacity to manage their money on a day to day basis there was no oversight in place of any transactions nor of the potential involvement of others with the residents accounts.

Where a resident did not have full access to their finances the inspector found that they were in receipt of for example, an 'allowance' from representatives who managed their money external to the provider. This resulted in permission being required for any spend over and above the amount given. Where a resident had expressed a wish to save for something specific they were not in a position to do so as they did not have access to the balance of their disability allowance. The provider was advocating for the resident to have access to their finances and had ensured that the resident was supported by an independent advocate. However, on the day of inspection the resident had no control over nor access to their personal finances and the provider had no safeguarding systems of oversight in place.

Judgment: Not compliant

Regulation 17: Premises

This centre comprises a large detached house in a rural setting. The centre is registered for a maximum of three individuals and is currently home to two residents.

Overall the centre is designed and laid out to meet the assessed needs of the residents living here. The house contains spacious communal areas including a kitchen, dining-area within a sun room, living room and utility room, the residents have their own bedrooms both of which are en-suite with a separate dressing area, a third bedroom also en-suite is currently unoccupied. There is a staff office where a resident was observed to comfortably move in and out of over the course of the afternoon to engage with staff and a bedroom for staff is also available on the first floor. Externally there is a large garden which had a football goal, trampoline and a patio area with seating that the residents had painted during the summer.

On the day of the inspection there was evidence of maintenance and repairs with a member of the provider's housing team cutting the grass and later completing repairs to the kitchen island and hanging a notice board in the hallway. There were

systems in place to log areas where maintenance and repairs were required. While there were minor areas of repair required these are reflected under Regulation 27 as areas requiring decoration impact on the effectiveness of cleaning.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy that contained all areas as required by the Regulation. The provider had ensured that risk management systems were in place in the centre. A risk register was in place which was regularly reviewed and had recently been updated. Plans were in place to appropriately respond to adverse incidents including loss of power, loss of water or flooding. A centre emergency plan was also available which was detailed and kept up-to-date.

Further to the previous inspection of this centre a system was in place for the recording of any accidents or incidents in the centre and adverse incidents were responded to appropriately. There was evidence that risk assessments were updated and changes made to control measures as required. Where control measures referred to the requirement for staff to have completed specific training this was for the most part in place and is reflected in the finding against Regulation 16 for newly recruited staff.

All residents had individualised risk assessments and risk management plans in place. Risk assessments were associated with restrictive practices and personal plans in addition to the development of risk assessments aligned to resident safety assessments. There was evidence that risks were reviewed and amended or closed as required and that new risks were opened, for instance the previous weeks governance audit identified the recent use of a newly purchased electronic tablet and the risks associated with Internet safety were being drafted as an outcome.

Judgment: Compliant

Regulation 27: Protection against infection

The provider and person in charge has ensured that measures were for the most part in place for protection against infection in the centre. The inspector found that all the frequently used living areas were clean on the day of inspection. Staff were observed over the course of the day completing cleaning tasks and they were familiar with the processes and procedures in place.

While there were suitable systems in place for laundry management, waste management arrangements required review as there was an overfull bin with a lid

that would not close externally and it was reported that it was often overfull close to collection day. This was stored next to where cleaning equipment was located externally.

There was a daily and weekly cleaning schedule used and cleaning rosters in place which were monitored and checked by the service manager with oversight from the person in charge. These schedules required review however, as they did not contain all rooms and areas within the designated centre. One room upstairs which was identified as needing review at the last inspection was still found to require cleaning and was filled with old furniture and materials. This was cleared out on the day of the inspection however, had not been monitored prior to the inspection by the systems in place. Systems and checks were also in place to monitor the water flushing procedures to protect against the risk of water-borne disease. A room downstairs was found that contained a fridge identified for use for storage of medicines, this fridge was found to contain out of date and mouldy foodstuff and the room was not included on the schedule for review and cleaning.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge ensured that there were appropriate and suitable practices relating to medicine management within the designated centre. This included the safe storage and administration of medicines, daily and weekly medicine checks, medicine sign out sheets and ongoing oversight by the person in charge. An additional process for stock take and review was in place for staff to complete during each shift. On a daily basis the individual medicine administration times of each of the residents was documented. This information was clearly visible and updated at the start of a shift to ensure all medicines had been correctly administered. There were clear systems for recording any medicines errors and outcomes following review of these.

All core staff had attended medicine management training and the person in charge outlined how they ensured ongoing competencies of all staff in the designated centre. All residents had been supported to complete a capacity assessment regarding self-administration of their medicine. There was evidence that one resident had been learning to take responsibility for self-administration of their medicines however, recent changes to the resident's health had resulted in changes to medicines such that the resident had requested staff take the responsibility back. This request and change was clearly documented.

The person in charge outlined the process followed by staff should medicines be required to support a resident while engaging in an activity away from the centre. This would include medicines that were not contained in blister packs and liquids.

There was signage to inform staff of safe medicine administration located on the medicine press and details on how to manage transporting medicines.

The person in charge had ensured that there were clear protocols in place for the use of 'as required' or PRN medicines and there was also a system in place for recording and reporting if a resident had refused to take a medicine as prescribed.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider and person in charge had completed substantial review of the management of behaviour that challenges within the centre since the last inspection. While residents continue to require support to manage their behaviour at times and had been involved in a number of serious incidents there was a consistent approach from staff when offering support and clear guidance in place.

Behavioural support assessments and plans were reviewed by the inspector and found these gave a clear account of the arrangements to support a resident in regards to their needs with behaviour that challenges. Plans were found to be regularly reviewed and amended to reflect a resident's current presentation. Plans contained guidance as indicated from other health and social care professionals such as occupational therapy or psychology or medical professionals such as psychiatry. The person in charge ensured there was follow up on medical advice and any changes to guidance or medication were completed in an effective manner.

Staff who met with the inspector understood these recommendations and they clearly described how best to create an environment which reduced the likelihood of behaviours that challenge occurring. They also outlined how they responded when behaviours of concern were present. This was of particular importance given significant previous incidents including episodes of potential self-harm, harm to others or the risks of absconding for residents who lived in this centre and their different needs and vulnerabilities.

There were a number of restrictive practices in place in the centre which were assessed for and implemented in line with national policy and best practice. There was evidence that residents gave consent for the use of restrictions in place and understood the reason for them. The staff team had received training to manage behaviour that challenges. The provider ensured that all restrictive practices were reviewed quarterly in their restrictive practice committee attended by all persons in charge and the provider. The provider also completed a monthly overview of all incidents and any use of 'as required' medicines alongside restrictive practices and amendments were made to positive behaviour support plans as required.

Judgment: Compliant

Regulation 8: Protection

Notwithstanding the areas of financial concern or vulnerabilities identified and referred to under Regulation 12 the provider had ensured the residents in this centre were protected from all other forms of abuse.

The provider had ensured there were robust safeguarding measures in place for the day-to-day care of residents in this centre. There were no current or active safeguarding plans currently in the centre. The staff members who met with the inspector had a good working knowledge of safeguarding measures, and all had received training in the area. The area of personal care was also well supported with clear policies and guidance in relation to areas such as privacy and personal hygiene.

There were support plans based on recent assessments in place. These included safety assessments for the residents in their home, when residents were together at home, for residents in the community and while engaged in learning, all of the plans promoted health and well-being while ensuring they were protected. There was clear guidance for staff on the recording and response to minor injuries in addition to guidance on supporting safe Internet access and use of electronic tablets and mobile phones.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that residents were for the most part supported to make decisions in their day-to-day lives. As already referenced under Regulation 12 this was not always the case in relation to financial decisions. The provider as stated had ensured that residents were referred to and met with independent advocates. The provider, person in charge and staff team ensured that residents' privacy and dignity were respected and promoted.

In addition there was evidence that independence skills were promoted whenever possible. Resident's consent was sought through the use of easy read forms. All those who lived in the centre met with their keyworker to discuss matters important to them and to decide on the organisation of their home. There was evidence that information was shared with residents regarding their rights and other matters important to them. One staff member discussed for example the supports in place to develop resident awareness of voting and their constitutional rights.

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 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Hazel Lodge OSV-0008104

Inspection ID: MON-0039997

Date of inspection: 28/09/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All staff members will receive a Human Focus account where they will be able to complete all mandatory trainings and refreshers. The deadline will be determined by PIC and monitored by her. The provider is able to view all staff training accounts, so it may inform PIC of the progress in completing trainings. Additionally, all new employees will be signed up for a Human Focus account and will have facilitated time upon their induction, spread out over two shadowing days to complete all mandatory training. Moreover, a list of all mandatory trainings will be sent to the agency manager for his staff who work at Hazelloege to complete them. Trainings matrix will be updated on a monthly basis by the PIC/manager of the center and reviewed by the PPIM. All outstanding mandatory trainings will be completed by the 30.10.23. A new training system is being rolled out in TerraGlen which facilitates a traffic light system, this will enable the PPIM and PIC to oversee what training needs are required each month, and will show the PIC what training is close to expiring and ensuring that all training is completed within the designated time frame.
The weekly services and governance report also captures identified training needs, which is overseen by the PPIM and Registered Provider.

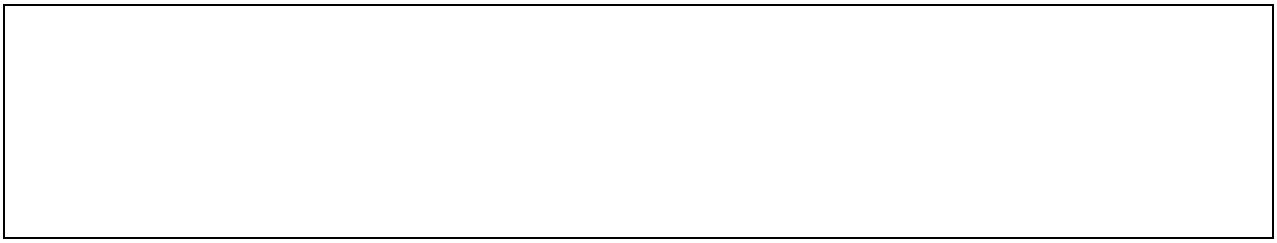
All supervision will be conducted in accordance with the company's policies every four to six weeks. PIC/manager will complete the supervision schedule to ensure that all supervisions are completed within the timeframe outlined in the company policies. Additionally, the house manager will perform a supervision audit every six weeks to determine if there are any outstanding supervisions. Until 28.10.23, all outstanding supervision as per HIQA inspection form 28.09.23 will be completed.
Monthly spot inspections completed by the PPIM will also provide further oversight and assurance around the completion of supervisions.
The weekly services and governance report also outlines a section whereby supervisions completed and required are reflected. This provides further oversight and assurance in ensuring that supervisions are kept up to date as per policy.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Both clients will be advised to establish a bank account that will be in their names and will only be accessible to them. A designated member of staff (key worker) will draft an agreement with service users that will help them protect their funds. In order to ensure this, clients and staff will withdraw bank statements on a monthly basis. Additionally, staff will encourage clients to open a safe account and to transfer the agreed amount of the weekly disability allowance to this account. An account will be opened in the client's name as well. Staff members will assist clients on a weekly basis with their shopping and financial management. Additionally, clients and staff will collect all receipts and keep them in the client's financial folders at the office. Our clients will be able to access these folders whenever they wish with the assistance of our staff. A series of key working sessions will be provided by the staff in relation to money management and money safety. Moreover, bank cards and money will be kept in a locked box provided to service users. It will be discussed with service users during consultations. Once a month, the PIC/manager will conduct an audit of the financial folders to ensure that bank statements and receipts are in place. Moreover, the PIC/manager will be responsible for overseeing (unauthorized) transactions on the bank statements. Each time clients withdraw money from the bank, they will be required to provide a withdraw slip, which will be kept in the financial folder. Staff support clients in a 1:1 ratio, so it will only be a matter of reminding and prompting them to complete this task. The Hazellodge team will have time until 04.11.23 to open a personal bank account for each client. It is anticipated that the situation with the transfer of disability allowance to a dedicated personal bank account will be resolved by 04.12.23

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The management will update the cleaning check list and add the back office and the room upstairs that were not in use at the time of the inspection. The task will be completed by 20.10.23. Additionally, the medication fridge will be added to the temperature fridge monitoring list and to the daily cleaning task list. The centre’s managers will contact the disposal waste company in order to obtain larger bins. This will be completed until 29.10.23.



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.	Not Compliant	Orange	04/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/10/2023

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 associated infections published by the Authority.	Substantially Compliant	Yellow	29/10/2023