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:	St Christopher's Centre
Name of provider:	Health Service Executive
Address of centre:	Cavan
Type of inspection:	Unannounced
Date of inspection:	14 January 2020
Centre ID:	OSV-0002447
Fieldwork ID:	MON-0025773

About the designated centre

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

This designated centre provides 24-hour nursing care and accommodates 13 male and female residents; eight residents for long-term residential care with a physical, sensory and or intellectual disability, two short-term respite care residents with a physical, sensory and or intellectual disability and three residents with palliative care needs. This designated centre is a purpose built bungalow, which is wheelchair accessible and is just outside a large town in County Cavan. The premises consists of 13 bedrooms all of which are en-suite and in close proximity to each other; a relaxation room; an activity room; an oratory; a family room including a spare bedroom, shower and living room for family; a large kitchen; dining room; and laundry room. There is also a clinical room, three offices, staff changing rooms with shower facilities, three toilets, three store rooms, a staff room and a filing room. The centre has a large garden surrounding the building on three sides. The centre has its own transport. The centre employs a full-time person in charge, a part-time clinical nurse manager (I), nine staff nurses, 13 care assistants, a chef, a clerical officer and a bus driver. The centre is nurse led meaning there is a nurse on duty 24 hours a day.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
14 January 2020	09:50hrs to 18:20hrs	Anna Doyle	Lead
14 January 2020	09:50hrs to 18:20hrs	Sarah Barry	Support

What residents told us and what inspectors observed

Due to the nature of the services being provided, which included end- of- life care, the inspectors did not get an opportunity to meet all of the residents on the day of the inspection.

On arrival to the centre two residents were waiting in the reception area to go to their day service. Both of the residents appeared happy to be going and engaged briefly with the inspectors. Inspectors spoke with residents who were having their dinner with the support of staff. Some of the residents were talking about a concert that they had attended the night before which they enjoyed very much.

One resident showed an inspector their artwork, which included finished projects and ones they were currently working on. They said they really liked the staff in the centre and got along with the other residents. The residents spoke very positively about the staff in the centre. They were very complimentary of the food provided and some spoke about directing their own community activities which they were happy with.

Some residents said that when staff were busy in the centre attending to other residents' needs that they may be required to wait for assistance. They were very understanding of this and said that staff were doing their best when these situations arose.

Capacity and capability

This centre was not being managed and operated in a way which was adequately meeting all of the residents' needs. This was a complex care environment where the provider was providing for a diverse range of needs including long- term residential services, respite care and end-of-life services. There were ongoing negative impacts on residents associated with the provision of this diverse range of services in the

one setting which the HSE (Health Service Executive), as provider, was not adequately responding to.

Following escalation in a number of other centres operated by this provider, under the same governance structure, the Chief Inspector of Social Services, was informed that there was a quality improvement structure in place to self identify and address areas of non-compliance. This structure had not been effective in relation to this centre. The provider had not self identified the core issues of non-compliance affecting this centre and there was no clear plan in place to address this situation. Due to the nature of findings from this inspection, the Chief Inspector took steps to meet with the provider and issue a warning letter, detailing the urgent nature of the non-compliance issues and the potential consequences of failing to address these.

While this centre had a defined management structure in place to oversee the care and support of residents, the inspectors found that significant improvements were required over a number of regulations inspected. Specifically in relation to fire safety, risk management, staffing, the layout and design of the premises, residents' rights and the management of complaints.

As a result of some of these findings, the provider was issued an urgent action plan the day after the inspection to provide assurances under risk management and fire procedures in the centre. The provider submitted these in a timely manner and assurances included a review of the fire safety measures in the centre by a fire officer and contact with the local fire brigade to assure a safe evacuation for residents. A review of risk management procedures in order to mitigate risks in the centre had also taken place.

The provider was not managing the staffing resources adequately. Staffing resources were not allocated in response to varying levels of need in the centre. There were 2.5 vacancies in the centre at the time of the inspection. The person in charge outlined a plan to address this and confirmed that one vacancy had been filled on a temporary basis and that staff in the centre were filling in the other vacancy until a replacement could be recruited.

This centre provided three different types of services to residents, however, the provider was not adequately managing the staffing resource to facilitate these services. There were four healthcare assistants and two nurses on duty during the day, from 8pm there were three staff on duty and there were two staff on duty from 10pm. Inspectors reviewed the staff rota in the centre and found that the actual rota was poorly maintained and the person in charge had to clarify if the correct amount of staff were on duty some days. While the person in charge provided assurances around this, improvements were required.

The inspectors were not assured following a review of some of the residents' support needs that there was sufficient staff in place to meet all of the assessed needs of the residents or in a timely manner at night. For example; most of the residents required the support of two staff for moving and handling, yet at night time there were only two staff on duty from 10pm onwards to support up to 13 residents. Staffing levels remained the same in the centre regardless of the number

of residents or the needs being supported in the centre. Given the specific support needs of some of the residents in the centre, the inspectors were not assured that the staffing levels were adequate to meet the needs of the residents. While residents spoke very positively about the staff in the centre, some said that there were times when they may have to wait for staff support as other residents' needs may take priority. Staff spoken with also verified this.

The inspectors also found that some residents had limited opportunities for meaningful activities outside of the centre. This is discussed in more detail later in this report. Staff said that activities both in the centre and in the community were dependent on the amount of staff on duty. Staff also reported that transport was limited at the weekends in the centre as the bus driver employed was off at the weekends and there were no staff licensed to drive the bus in the centre.

Staff were observed responding to multiple demands on the inspection supporting the residents in the centre. The centre itself was observed to be very busy, there were numerous visitors to the centre and the activity levels in the centre did not resemble that of an ordinary home given that eight residents lived there on a full-time basis. Staff spoke about the difficulty in working with the varied assessed needs of residents in the centre and how the demands in one area of service provision of the centre affected residents' care in other areas. This was also verified in one record viewed where it was recorded that staff reported difficulties supporting one resident who could shout when anxious, and this impacted on other residents in the centre who may be very unwell. A record of complaints in the centre also found that one resident had reported concerns about another resident who was availing of respite services at the time due to their behaviours of concern.

Staff also expressed concerns regarding the fire evacuation process at night when only two staff were on duty and also in relation to the supervision of residents at night.

A review of a sample of supervision records demonstrated that the person in charge provided formal supervision to staff members on a six-monthly basis. The training records viewed found that some staff had not completed all mandatory training requirements, including in fire safety, hand hygiene and standard precautions and CPR training. There were some gaps identified in refresher training also. Staff had been provided with additional training in the management of epilepsy to meet the specific needs of residents; however, not all staff had completed this training. This had been an area of improvement identified from the last inspection.

The provider had some systems in place to ensure that the services being provided were monitored and evaluated. Overall, these systems were not identifying some of the key areas of negative impact identified on this inspection. Regular audits were conducted in areas such as infection control, medication administration and risk management. The findings of these audits were in general positive, however some areas of improvement identified had not been implemented. For example, an infection control audit found that a task needed to be added to the cleaning schedule and this had not been done. A risk management audit also recommended

that a risk assessment be conducted on working from a height, this had not been done either.

An unannounced quality and safety review had been completed every six months as required under the regulations along with an annual review for 2019. Inspectors found that these audits were identifying areas of improvement. For example; it had been identified that residents' social goals needed to be developed. However, the overall quality and effectiveness of the service provision had not been adequately assessed.

Additionally, in the minutes of a staff meeting held in August 2019 it had been identified that the assembly fire evacuation point was not safe and needed to be reviewed. This had not been addressed at the time of the inspection.

The provider was not demonstrating that they were listening to and adequately responding to residents' feedback. There was a compliment and complaints log in place in the centre. Inspectors reviewed a number of compliments from residents and their family members, praising the quality of care being provided in the centre. There was evidence that residents were aware of how to make a complaint and were supported by staff to do so. Information regarding the complaints process was also displayed in the centre, in an accessible format.

Notwithstanding these practices, a review of the complaints from 2019 showed that complaints were being discussed with residents but they were not being dealt with appropriately. One resident complained about the same issue three times and no proactive measures were taken to address the matter.

A review of incidents in the centre demonstrated that the provider was maintaining a record of all incidents occurring in the designated centre and, where required, they had been notified to the Chief Inspector.

There was CCTV used on the external grounds of the centre for security purposes. Inspectors reviewed the policy on the use of CCTV and found that it had not been updated to reflect the most recent changes in legislation.

Overall, this service required substantial review and improvement to ensure that it was appropriately resourced and organised to meet the diverse range of needs presented by residents.

Regulation 15: Staffing

Inspectors were not assured that the staffing levels in the centre were sufficient to meet the assessed needs of the residents given the diversity of the services provided. Staffing resources were not responsive to changing levels of need in the centre.

The actual rota was a poorly maintained record which required review.

Judgment: Not compliant

Regulation 16: Training and staff development

The training records viewed found that some staff had not completed all mandatory training requirements, including fire safety, hand hygiene and standard precautions and CPR training. There were some gaps identified in refresher training also. Staff had been provided with additional training in the management of epilepsy to meet the specific needs of residents however; not all staff had completed this training.

The person in charge conducted supervision with staff every six months.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not ensured that the centre was appropriately organised and resourced to provide effective care. Given the findings of this inspection, inspectors were not assured that the systems in place to monitor and evaluate care were effective or that the centre was adequately resourced to ensure the effective delivery of care and support.

The findings from some audits conducted in the centre had not been implemented.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of incidents in the centre demonstrated that the provider was maintaining a record of all incidents occurring in the designated centre and where required they had been notified to the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaints from 2019 showed that complaints were being discussed with residents but they were not being dealt with appropriately. One resident complained about the same issue three times and no proactive measures were taken to address the matter.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The policy relating to the use of CCTV in the centre had not been reviewed to reflect the most recent legislation pertaining to its use.

Judgment: Substantially compliant

Quality and safety

Inspectors found that while some aspects of the service were positive, such as food and nutrition, significant improvements were required to ensure the overall quality and safety of care being provided. The design and layout of the centre was impacting on the privacy and rights of some residents. Risk management and fire safety required significant review as discussed earlier in the report. Other areas of improvement included residents' access to meaningful activities in their community and the progression of personal goals for some residents.

The premises were large, spacious and clean. Some areas of the centre required improvement. For example; an activity room in the centre was also being used to store a large hospital bed and wheelchair. This activity room also contained a dining table where residents could choose to have their meals if they wished. This environment was cluttered and it was not conducive to a homely dining experience for residents.

On a walk around of the centre, inspectors observed that some of the equipment and radiators were rusted, particularly in some en-suite bathroom areas. A malodour was present in two of these en-suites and the person in charge said that this was due problems with the drainage of water from the showers. The person in charge

said that the provider was in the process of addressing this. This was evident in the quality improvement plan for the centre where it had been identified that five en-suite bathrooms needed to be updated. The completion date for these was March 2020.

Inspectors were not assured that the design and layout of the centre was suitable to provide appropriate care to the residents. For example; all of the bedrooms were in close proximity to each other and, given the nature of the services provided, there were regular visitors to the centre who had to access the corridor where residents' bedrooms were in order to visit their family members. This access was required at all times of the day and night. The inspectors discussed these concerns at the feedback meeting with the provider.

A sample of personal plans viewed found that all residents had an assessment of needs completed. Support plans were in place to guide how residents were to be supported. Residents had access to allied health professionals through community teams. From the sample viewed, residents had been supported to attend national health screening clinics where required. Residents had goals identified in their plans, however, some of the goals had not been achieved. For example, a resident had chosen a goal in August 2019 to go on holidays; however, this had not progressed at the time of the inspection.

Five residents attended day services external from the centre. The person in charge stated that the other residents were supported with meaningful day activities within the centre. However, on the day of the inspection only one planned activity took place in the centre. While some residents liked to arrange their own activities during the day, inspectors were not assured that all residents had access to meaningful activities in the centre. For example; one resident's activity schedule for December 2019 found that other than attending a day service, the resident did not leave the centre at the weekends or in the evening time during that month.

Meals were provided from a centralised kitchen in the centre. Residents and staff were not permitted access to the central kitchen due to infection control issues. However, the provider had made provisions in another room in the centre for residents to cook small meals and bake and avail of snacks. Residents said that they loved the food prepared in the centre. Choices were provided at mealtimes and other options were also available should residents prefer an alternative.

Residents had access to allied health professionals, where required, regarding dietary requirements and both staff and the chef in the centre were aware of the needs of the residents. Staff were observed supporting residents in the centre at lunchtime and were providing support to the residents where required.

Staff had been provided with training in positive behaviour support, some staff had not completed refresher training in this at the time of the inspection (as discussed under Regulation 16: Training). Residents who required this support had a plan in place to guide staff practice in this area. This plan outlined what staff needed to do to support the resident. However, a review of one plan indicated that staff had some concerns around effectively implementing the supports outlined for the resident due

to the layout and design of the centre and the care and support needs of the other residents there. (This is addressed under Regulation 17: Premises).

The arrangements for risk management and fire safety required review. The provider had ensured that the centre had suitable fire equipment and it was serviced as required. Emergency lightening was in place throughout the centre. Some staff in the centre had not completed fire safety training. The evacuation procedure for the centre did not guide practice. For example; the person in charge outlined that the evacuation procedure included a horizontal evacuation of the centre; however, this was not reflected in any records viewed. The assembly point was also located in an area that was not safe and could hinder the arrival of emergency services. As detailed previously, this had been identified as a concern at a staff meeting in August 2019 and had not been addressed at the time of the inspection. Two fire exits were also blocked on the day of the inspection which the person in charge confirmed would be addressed prior to the inspection being completed. It was also not clear how residents should be supervised in the event that they had to be evacuated from the centre when only two staff were on duty in the centre.

Personal emergency evacuation plans were in place for residents; however this was not consistent for all residents.The provider had conducted six fire drills in 2019, the last one in April 2019. While all fire drills involved the lowest staffing ratio and the evacuation of all residents, one of the evacuation times had taken in excess of 30 minutes to complete. Given these findings, the provider was issued with an urgent action plan the day after the inspection to address these findings.

Risk management systems also required review. All incidents were recorded on an incident report form which was then reviewed by the person in charge. Incidents were then discussed at staff meetings in the centre. Risk assessments were in place around environmental risks and, where required, residents had individual risk assessments in their personal plans. However, some of the assessments were not risk rated. The inspectors also found that one resident, who had eight falls in the centre which were not witnessed and who was also more susceptible to a significant injury, did not have adequate control measures in place to ensure that the resident was safe at all times (particularly at night time). There were also three risk assessments in place pertaining to falls for this resident and all of them contained conflicting information. One stated that the resident required supervision for some manual handling transfers another stated that the resident may require supervision in this area. One of the risk assessments had not been reviewed since May 2019 despite the resident sustaining eight falls in the last year. Given these findings, the provider was issued with an urgent action plan the day after the inspection to address risk management.

The inspectors also found that some of the practices in the centre were institutional in nature. For example, there were notices on the walls in residents' bedrooms indicating particular laundry requirements. Some furniture was labelled with white stickers to indicate what garment should be stored there. These practices were not respecting residents' rights to dignity and respect in the centre.

Regulation 13: General welfare and development

Some residents had limited access to meaningful activities in the centre and in their community.

Judgment: Not compliant

Regulation 17: Premises

The design and layout of the centre was impacting on the quality of life of some of the residents in the centre as evidenced in complaints and other documents reviewed.

While, the provider had highlighted that five of the en-suite bathrooms needed to be remodelled, inspectors found that the malodour from two of these was not pleasant. The person in charge indicated that this malodour was related to drainage problems in the en-suites.

Some radiators and equipment stored in the en-suite bathrooms were rusted.

An activity room in the centre was also being used to store a large hospital bed and wheelchair. This activity room also contained a dining table where residents could choose to have their meals if they wished. This environment was cluttered and it was not conducive to a homely dining experience for residents.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents said that they loved the food prepared in the centre. Choices were provided for at meal-times and other options were also available should residents prefer an alternative.

Residents had access to allied health professionals where required regarding dietary requirements and both staff and the chef in the centre were aware of the needs of the residents. Staff were observed supporting residents with their meals in the centre at lunchtime.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management systems required review. Appropriate measures were not in place for one resident who was at risk of falls in the centre.

Some risk assessments were not assessed to indicate the level of risk attributed to them.

There was conflicting information in three risk assessments contained in one residents plan.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire evacuation plan did not guide practice the practice in the centre.

The assembly point was located in an area that was not safe and could hinder the arrival of emergency services.

The provider had conducted six fire drills in 2019, the last one being in April 2019. The records viewed indicated prolonged evacuation times, one fire drill took in excess of 30 minutes to complete.

Some of the fire exits were blocked on the day of the inspection.

It was also not clear how residents should be supervised in the event that they had to be evacuated from the centre when only two staff were on duty in the centre

Some staff had not completed fire training.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had an assessment of need contained in their personal plans. Support plans were in place to guide practice. Personal plans were being reviewed. Goals

had been developed with residents; however,as identified by the provider some of these goals were not progressing.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were being provided for with access to allied health professionals through community teams. Residents had been supported to attend national health screening clinics where required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff had been provided with training in positive behaviour support, some staff had not completed refresher training in this at the time of the inspection (as discussed under training). Residents who required support in this area had a plan in place to guide staff practice in this area. This plan outlined what staff needed to do to support the resident.

Judgment: Compliant

Regulation 9: Residents' rights

The overall organisation of the service was impacting on residents' rights. The diverse range of services being provided in the centre were impacting negatively on all resident groups. Some of the practices in the centre were institutional in nature. For example; residents did not have access to all parts of their home, there were notices on residents' bedroom walls indicating specific laundry requirements for residents. Furniture had stickers on the drawers to guide staff where items of clothes should be stored.

Judgment: Not 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 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Christopher's Centre OSV-0002447

Inspection ID: MON-0025773

Date of inspection: 14/01/2020

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: In order for this centre to come into compliance with this regulation the following actions have been undertaken: • A new roster has been introduced within the centre to reflect clearly the current staffing on duty each day. Completed – 17-2-2020 • A planned and actual roster is now available within the centre. Completed – 17-2-2020 • Following roster review on 11/2/2020 1 additional care staff rostered between the hours of 8pm to 8am. • The roster for this centre will remain under review depending on the needs of the palliative care patient at any given time.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In order for this centre to come into compliance with this regulation the following actions have been undertaken: • A full training needs analysis has been conducted by the Person in Charge on 17/2/2020. A number of training deficits were identified. All identified training needs have now been completed by all staff with training certificates on site as evidence of completion. • All staff have completed moving and Handling training- Completed – 14/2/2020 • All staff have completed Positive Behavior Support - Completed – 18/2/2020 • All staff have completed CPR – Completed – 21/2/2020	

- All staff have completed Fire Safety – Completed - 25/2/2020
- All staff have completed Hand Hygiene – Completed – 2/3/2020
- All staff have completed Epilepsy Introduction – 18/2/2020
- All staff have completed Positive Behavior Support - 18/2/2020
- All staff have completed PMAV (Professional Management of Aggression & Violence) – Completed - 27/2/2020

- Buccal midazolam training for two staff will be completed by 16-3-2020

- All outstanding fire training certificates for staff have been sourced and are available on site.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In order for this centre to come into compliance with this regulation the following actions will be undertaken:

- Following roster review on 11/02/2020 1 additional care staff rostered between the hours of 8pm to 8am.
- The roster for this centre will remain under review depending on the needs of the residents at any given time.
- A review of all audits was conducted on 11/02/2020 by Person in Charge and Director of Nursing and all actions identified have now been implemented. All future audits undertaken and where appropriate actions identified will be added to the centre's Quality Improvement Plan for implemenation.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

In order for this centre to come into compliance with this regulation the following actions will be undertaken:

- A review of respite service user has been undertaken to ensure that respite admissions to the centre are compatible with the current resident group and do not impact negatively on the rights of long term residents.
- Complaints within the centre will be addressed immediately and reviewed on a weekly basis by Person in Charge to ensure they are closed out.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

In order for this centre to come into compliance with this regulation the following actions will be undertaken:

- The CCTV policy for the centre has been reviewed to reflect the most recent changes in legislation pertaining to its use. - Completed - 28/2/2020

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
In order for this centre to come into compliance with this regulation the following actions have been undertaken:

- A full review of all residents' goals and activities has been undertaken by Person in Charge. Completed -11/2/2020.
- The current staffing roster has been reviewed and staff are now assigned to support all residents with social activities on a daily basis as per their individual choice. Completed - 11/2/2020
- All activities for residents are now clearly documented as part of each resident's personal plan. Levels of participation and engagement in activities are now documented. Completed - 11/2/2020 and ongoing

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

In order for this centre to come into compliance with this regulation the following actions will be undertaken:

- All radiators that require attention will be repainted. This will be completed by the 3/3/2020.
- The activity room within the centre for residents has been re organised. This room is now spacious and homely for residents to enjoy activities. Completed – 1/2/2020
- A second activity room has been developed within the centre to facilitate residents who wish to avail of the computer facilities. Completed- 17-1-2020

- All labels and white stickers have been removed from all individuals' bedroom furniture to promote a more homely and less clinical environment. Completed - 16/1/2020.

- The Infection Control and Maintance Department are scheduled to conduct an assessment of the five en-suites within the centre. This assessment is scheduled for 04/03/2020.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Below sets out the current risk management system in place at St. Christopher's Centre: There is currently a health and safety risk management system in place which documents all risks pertaining to the centre. Each resident has an individual risk assessment and associated management plan as part of their person centred plan.

In order to bring the service into compliance with this regulation the following will be undertaken:

- The centre's risks have been reviewed with a focus on potential emergency situations such as fire – completed 17/01/2020.
- Each individual resident's risk assessment has been reviewed with input from multi-disciplinary team members as required - completed 17/01/2020.
- To ensure the system for responding to a fire emergency is fit for purpose and education for staff, an onsite visit by HSE Fire Prevention Officer and Chief Assistant Technical Services Officer was conducted. – completed 25/02/2020.
- The assembly point has now been relocated to the side car park. – completed 17/01/2020
- A second activity room has been developed within the centre to facilitate residents who wish to avail of the computer facilities to ensure adequate supervision. - completed 17/01/2020.
- One resident's falls risk assessment has been reviewed by the Occupational therapist on 17/1/2020. A device has been fitted to this resident's wheelchair which will alert staff if this individual is ascending from the chair. This will be reviewed on a monthly basis – complete 17/1/2020.
- All other risk assessments for this individual have also been reviewed. Complete 17-1-2020.

Regulation 28: Fire precautions	Not Compliant

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

Below sets out the arrangements currently in place in St. Christopher's to ensure compliance with the relevant fire regulations as approved by Fire Officer.

The means of escape strategy within the St, Christopher's Centre is that of Progressive Horizontal Evacuation. In a setting such as St. Christopher's Centre, where occupants are totally dependent on other people for evacuation, 'self-help' evacuation procedures are inappropriate. As such, Progressive Horizontal Evacuation is the escape strategy recommended by the commissioned Fire Safety Engineers (FCC) and is the strategy currently adopted within St. Christopher's Centre.

The escape routes have been designed to facilitate this managed evacuation approach. The building is divided into 7 different compartments (each compartment separated from its adjacent compartment by way of 30 minute fire resisting construction.). It is also noted that each bedroom within this building is also separated from the corridor and any adjacent room by way of 30 minute fire resisting construction (protected corridor) incorporating FD30S fire doors.

The evacuation strategy is to firstly, notify the local fire services, and secondly, evacuate any occupants from their individual bedroom (assuming the fire is located within their room). Staff would evacuate this occupant firstly and close the door to the bedroom behind them (this in effect contains the fire within this room by way of its 30 minute fire resisting enclosure). Staff would then evacuate this occupant into the adjacent compartment and then return and evacuate the next adjacent bedroom until all occupants from a single compartment is evacuated to their adjacent compartment which is considered a place of relative safety. This adjacent compartment provides staff with additional time to make preparations to start the evacuation of this compartment if required.

The building is provided with an L1 addressable fire detection and alarm system. This provides early warning in the event of a fire.

All staff are provided with annual fire safety training.

Given the type of occupants that are accommodated within St. Christopher's, day/night time evacuation drills are not carried out on vulnerable residents. Night time evacuation procedures are simulated as part of our fire safety evacuation training and the relevant numbers of staff on night duty are reflected in this training with the instruction that if a situation arises at night or indeed at any time that their immediate action is to notify the local fire services who have been briefed on the nature of the service and have indicated a response time of 15 minutes in such an event.

In order to bring the service into compliance with this regulation the following will be undertaken:

- To ensure the system for responding to a fire emergency is fit for purpose and education for staff, an onsite visit by HSE Fire Prevention Officer and Chief Assistant Technical Services Officer was conducted. – completed 25/02/2020.
- The assembly point has now been relocated to the side car park. – completed 17/01/2020

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

In order for this centre to come into compliance with this regulation the following actions have been undertaken:

- A full review of all residents' goals and activities conducted by Person in Charge. Completed -11/2/2020.
- The current staffing roster has been reviewed and staff is now assigned to support all residents with social activities on a daily basis as per their individual choice. Completed - 11/2/2020
- All activities for residents are now clearly documented as part of each resident's personal plan. Levels of participation and engagement in activities are now documented. Completed - 11/2/2020 and ongoing
- Annual reviews for all residents have been completed on the 26/2/2020 with new goals and activities identified and agreed. Completed – 26-2-2020

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

In order for this centre to come into compliance with this regulation the following actions have been undertaken:

- A review of respite service user has been undertaken to ensure that respite admissions to the centre do not impact negatively on the rights of long term residents.
- A review of all residents' goals and activities have been conducted by Person in Charge to ensure that all residents expressed wishes and choices are catered for.
- The current staffing roster has been reviewed and staff is now assigned to support all residents with social activities on a daily basis as per their individual choice. Completed - 11/2/2020
- Decongregation - Agreement has been reached with St Christopher's voluntary group, CHO 1, National HSE and the Department of health that this facility will be developed as an Inpatient Palliative Care Unit. This requires a process of decongregation in partnership with residents and the provision of housing with care in the community. Local Disability services will initiate a process in 2020 to finalise proposals including timeframes to deliver same.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	11/02/2020
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	11/02/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the	Not Compliant	Orange	17/02/2020

	size and layout of the designated centre.			
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.	Not Compliant	Orange	17/02/2020
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.	Not Compliant	Orange	16/03/2020
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	04/03/2020
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.	Not Compliant	Orange	04/03/2020

Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	03/03/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	11/02/2020
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	11/02/2020
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.	Not Compliant	Red	25/02/2020
Regulation 28(2)(b)(i)	The registered provider shall	Not Compliant	Orange	25/02/2020

	make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
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.	Not Compliant	Red	25/02/2020
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	25/02/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable,	Not Compliant	Red	25/02/2020

	residents, are aware of the procedure to be followed in the case of fire.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/01/2020
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	28/02/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	26/02/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy	Not Compliant	Orange	03/03/2020

	and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			