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:	Roseville
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	27 February 2020
Centre ID:	OSV-0005738
Fieldwork ID:	MON-0024015

About the designated centre

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

Roseville designated centre provides community based living arrangements for up to three adult residents. Roseville is a modern and spacious property that provides residents with a high standard living environment which meets their assessed mobility and social care needs. Each resident has their own bedroom. This service provides supports for residents with severe to profound intellectual disabilities and complex needs. The provider identifies that residents living in this centre require high levels of support and has staffing arrangements in place to ensure residents needs are met. There is a full-time person in charge assigned to the centre, three staff during the day to support residents in having a full and active life and one waking night staff to ensure residents night time needs are met. The centre is resourced with one transport vehicle to support residents' community based activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 27 February 2020	10:30hrs to 17:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the three residents currently residing within the designated centre during the inspection. On arrival to the centre two residents had gone to a local seaside area for a day trip. The other resident remained at home in the centre as they do not enjoy long periods of time away from the centre. This resident was supported to engage in a number of activities with staff.

The individual enjoyed listening to classical music with this playing in the background on their i-pad, they went for a walk around the local area, had their nails painted by staff and had some relaxing time in their bedroom. Staff were very cognisant to the communication needs of the resident and responded accordingly throughout the day. The resident chose not to interact with the inspector and this choice was respected.

When the two residents returned from their day trip they were supported in their return to the centre. Staff expressed on the residents behalf that a good day was had by all. Residents had lunch out and stopped off on the way home to collect groceries for the house.

All interactions observed were positive in nature and residents appeared very comfortable and relaxed in the company of staff.

Capacity and capability

The inspector reviewed the capacity and capability of the service being provided within the centre and overall a high level of compliance was found. The registered provider was actively engaging with the current governance team to ensure clear roles and responsibilities were in place with clear lines of accountability. Some improvements were required in the areas of written policies and procedures and in the area of staff training and development to ensure compliance to regulations.

The registered provider had ensured that a suitably qualified an experienced person in charge had been allocated to the centre. This person was supported in their role by an appointed team leader. In recent weeks prior to the inspection a review of administration hours of the person in charge had been competed to ensure that sufficient time had been allocated to complete governance duties such as notification of incidents and maintaining oversight to the day to day operations of the centre.

The registered provider had ensured the allocation of a governance structure within

the centre. The registered provider in conjunction with members of the governance team were ensuring that clear lines of accountability were in place and all members of the team were aware of the role and responsibilities within the centre. At organisational level a number monitoring systems were utilised to ensure oversight was maintained to the needs of the service. This included an annual review of service provision and a six monthly unannounced visit to the centre. This had occurred on the day prior to the inspection with the report writing process underway.

The person in charge with the support of the appointed team leader had completed a plethora of centre level monitoring systems. The team leader had contacted the relevant personnel to highlight the requirement of the need for completion of their allocated audit. For example, finance department and complaints. Whilst an organisational audit schedule was in place to ensure that all areas of service provision was monitored in a set timeframe by an appointed person improvements were required to ensure that this schedule was adhered to.

The registered provider had ensured the allocation of an appropriate staffing level to the centre. The staff roster was flexible and ensured that the required staff supports were afforded to residents at all times. The person in charge had maintained a record of training within the centre. However, due to the format of the records it was unclear if all staff were up to date on the training the provider had deemed as mandatory including refresher training. Following discussions with person in charge and team leader a review of training records was to be completed. Assurance was given with regard to mandatory training that if a staff had not completed refresher training a place on appropriate course had been booked for the coming weeks.

The staff team were supported to raise any concerns or issues within the centre through staff meetings and face to face interactions. The role of completion of formal staff supervision through quality conversations was currently allocated to the team leader with a view to increase conversations being completed by the person in charge. Whilst a number of conversations were reviewed were to a high quality and effective improvements were maintained to ensure adherence to organisational policy for all staff.

Whilst the registered provider had ensured the development of written policies and procedures required under Schedule 5 of the Health Act 2007, this has not been reviewed within the regulatory required time frames. This area of non-compliance had been highlighted the registered provider as part of inspections of other designated centres under there remit and actions put in place to address same had not been adhered to. This did not ensure that staff members were afforded with the most relevant guidance in accordance with best practice.

Regulation 14: Persons in charge

The registered provider had ensured a suitably qualified and experienced person in

charge had been appointed to the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that the number, qualifications and skill mix of staff allocated to the centre was appropriate to the assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

It was unclear from records maintained within the centre if the person in charge had ensured staff had access to appropriate training including refresher training.

Improvement was required to ensure that all staff received formal supervision in accordance with the organisational policy.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents within the centre containing the regulatory required information.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had ensured the allocation of a clear governance structure to the centre. The provider is actively engaging with governance team to ensure roles and responsibilities are clearly laid out.

Some improvements were required to ensure monitoring systems are implemented in accordance with the organisational audit schedule.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development and ongoing review of the statement of purpose, including all information as requried under Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all incidents had been submitted in accordance with regulatory requirement.

Judgment: Compliant

Regulation 4: Written policies and procedures

Whilst the registered provider had ensured the development of written policies and procedures required under Schedule 5 of the Health Act 2007, this has not been reviewed within the regulatory required time frames.

Judgment: Not compliant

Quality and safety

Roseville presented as a warm, clean and homely centre. Each resident was supported by staff to have their individual bedrooms personalised to their tastes and interests. Whilst overall the centre presented in a good state of report some minor improvements were required to ensure that all areas were maintained to a high standard. Also, within the kitchen area the installation of handrails was required to be completed in accordance with multidisciplinary recommendation. Staff supported residents in a respectful and dignified manner. Residents and their representatives were consulted in the day to day operations of the centre where possible.

Overall, the registered provider had ensured that residents were facilitated and supported to participate in a range of meaningful activities. They were supported to

develop and maintain personal relationships and links in the wider community. Some improvements was required to ensure any change to one individual's plan did not impact on others. Residents had daily planners in place which were developed with staff support on a Sunday evening as part of the weekly residents meeting. On the day of inspection, one residents planner had changed, this resulted in another resident not being able to complete their daily planner of going to the local supermarket for the groceries.

The person in charge had ensured that each individual had a comprehensive personal plan in place. This provided staff with clear guidance on support needs of residents and incorporated monthly review. Whilst an annual multidisciplinary review was completed an annual visioning meeting had not occurred to ensure personal goals reflected the aspirations of individual. Due to these meetings not occurring residents were not encouraged or facilitated to plan personal goals, and staff not assured of supports which were required to meet these goals,

Individuals personal plans did encompass guidance for staff to ensure a plethora of support needs were supported in a respectful and dignified manner. Care plans had been developed to ensure a consistent approach to healthcare needs and personal and intimate care for example, falls care plan and stoma care plan. Staff spoken had a clear understanding of these support needs.

The registered provider had not ensured that effective measures were in place for assessment, management and ongoing review of risk. Arrangements for the storage of oxygen were not in adherence to best practice guidelines and did not ensure safety for all, this included the location of oxygen cylinder and the appropriate signage required. A risk register had been developed ad maintained within the centre. However, where additional control measures had been identified, the implementation and effectiveness of these measures had not been clearly evidenced within the register. Also, a number of risks had not been identified including lone working (day duty) and presence of oxygen cylinder within transport vehicle.

Whilst effective systems were in place for the ongoing supply, storage and prescribing of medicinal products, improvements were required with respect to administration process to reduce the risk of error. A number of errors had been reported with respect to non-administration of medications whilst some measures had been implemented to address this, a holistic approach was not in place. For example, one action was for double checking of stock following administration of medications. On the day of inspection however, one staff was present with no individual present to complete the double check.

The registered provider had ensured effective fire safety systems were in place for the detection and containment of fire. Through regular checks and servicing of all fire fighting equipment the registered provider was assured that all equipment and systems were in working order. Residents and staff were afforded with knowledge and guidance relating to safe evacuation of the building in the event of an emergency. A centre specific emergency evacuation plan was utilised in accordance

with personal emergency evacuation plans. Regular evacuation drills were completed taking into account a number of scenarios to promote awareness.

Regulation 13: General welfare and development

Overall, the registered provider had ensured that residents were facilitated and supported to participate in a range of meaningful activities. They were supported to develop and maintain personal relationships and links in the wider community. Some improvements was required to ensure any change to one individual's plan did not impact on others.

Judgment: Substantially compliant

Regulation 17: Premises

The premises presented as warm, clean and homely. Residents were supported ot have individual bedrooms decorated in accordance with their unique interests and tastes.

Some external work was required to ensure that all areas of the centre ws in a good state of repair. Internally items of equipment were required to be fitted in accordance with multi disciplinary recommendations.

Judgment: Substantially compliant

Regulation 20: Information for residents

A residents guide was in place containing the regulatory required information

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that effective measures were in place for assessment, management and ongoing review of risk. Arrangements for the storage of oxygen were not in adherence to best practice guidelines and did not ensure

safety for all, this included the location of oxygen cylinder and the appropriate signage required.

A risk register had been developed ad maintained within the centre. However, where additional control measures had been identified, the implementation and effectiveness of these measures had not been clearly evidenced within the register. Also, A number of risks had not been identified including lone working (day duty) and presence of oxygen cylinder within transport vehicle.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had ensured effective fire safety systems were in place for the detection and containment of fire. Residents and staff were afforded with knowledge and guidance relating to safe evacuation of the building in the event of an emergency.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Whilst effective systems were in place for the ongoing supply, storage and prescribing of medicinal products, improvements were required with respect to administration process to reduce the risk of error.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each individual had a comprehensive personal plan in place. This provided staff with clear guidance on support needs of residents and incorporated monthly review. Whilst an annual multidisciplinary review was completed an annual visioning meeting had not occurred to ensure personal goals reflected the aspirations of individual.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had ensured that each resident was supported to achieve and maintain the best possible physical and mental health.

Judgment: Compliant

Regulation 8: Protection

The registered provider had ensured that each resident was assisted to protect themselves from abuse. Where a safeguarding concern was identified, measures were implemented to protect the individual from all forms of abuse.

The personal and intimate care needs of all residents was laid out in personal plan in a dignified and respectful manner.

Judgment: Compliant

Regulation 9: Residents' rights

The centre operated in a manner which respected the privacy and dignity of residents. Where possible residents were consulted and supported to consent to decisions about their care and supports.

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Roseville OSV-0005738

Inspection ID: MON-0024015

Date of inspection: 27/02/2020

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
SPC employees are supported to attend mandatory and mandated training. It is also the responsibility of staff to propose training that would enhance and support their role within St. Patrick's Centre (Kilkenny).

A centre specific training profile, individual staff training profiles and a training schedule are distributed monthly to the PIC, Team Leader and PPIM of the centre by the Training Department. Staff training is on the agenda of the monthly team meetings and also discussed at Quality Conversations.

Zero tolerance regarding outstanding training:
As part of the learning from the inspection in another SPC designated centre in February 2020, the Quality Assurance Group met on the 19/02/2020. At this QA meeting it was discussed with all PIC's and Team Leaders to follow up with their staff teams on outstanding training needs and ensure refresher training is booked in a timely manner to ensure compliance in regards to training needs.

At the Senior Management Team Meeting on the 11/03/2020 zero tolerance regarding outstanding training of employees was agreed.

Layout of training reports:
SPC training department has changed the layout of monthly training reports. Colour codes are
- highlighting outstanding training needs in red.
- highlight in amber when a refresher training will be due for completion.

Quality department has also discussed with SPC training department to amend the layout of training reports to ensure dates are visible at all times. This is not yet implemented, but will be discussed further with the training department.

Quality Conversations:
There is a Quality Conversations policy in place. The policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for staff. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

The PIC is completing Quality Conversations with the Roseville staff team on a 6 weekly basis and has a schedule for same in place. Action plans are developed with the staff members as part of their Quality Conversations.
To ensure the action plans are followed through by staff members, the Team Leader in Roseville has regular Action Plan Conversations to support the team in completing delegated duties.

The PIC was also attending three training sessions on the 6th and 28th February and 10th March 2020 to build capacity around Leadership and Quality Conversations. The Team Leader was able to attend one of the training sessions and is building her knowledge through own Quality Conversations, Feedback of PIC and PPIM and also through Action Plan meeting with the staff team.

Training during the COVID-19 pandemic:
Since the outbreak of the COVID-19 pandemic SPC has risk assessed the completion of training. To adhere to the national guidelines around social distancing bur also ensure that SPC staff is appropriately trained, online courses are being offered for following training:
• Safeguarding
• Manual Handling
• PPE equipment
• Hand washing
• Children First

SPC is currently sourcing video/online training as regards to fire equipment.

Medication administration, Buccal and Oxygen training are still being provided by the SPC medication officer to small groups of six staff members attending applying to the social distancing advice.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A PPIM and PIC are assigned to Roseville to ensure clear governance structure for the

designated centre. The PIC has also assigned PIC duties to another SPC designated centre and is therefore supported by an acting Team Leader in Roseville with delegated duties by the PIC.

The PPIM is completing monthly to 6 weekly Quality Conversations with the PIC and Team Leader and also meet on a monthly basis for Cluster meetings. Action plans arising from audits, inspections and reviews are informing Quality Conversations and delegated duties. The PPIM reports directly to the Director of Service.

Audits:
Annual and six monthly provider audits are completed for Roseville and actions arising out of these audits are being followed through in Quality Conversations and Team Meetings.

Some audits were not completed in a timely manner by SPC departments as per audit schedule. The Team Leader has requested outstanding audits to be completed.

Due to the outbreak of COVID-19 and restrictions on visits to SPC designated centres audits will be completed as per phone and email conversations to ensure management and oversight.

Action Plans:
Learning from inspections in two designated centres in February 2020 regarding the usage and completion of action plans was discussed with all CSM's, PIC's and Team Leaders at Quality Assurance Meeting on the 19/02/2020.

An action plan template is available for all staff on SPC Q drive to document:
- items discussed
- actions
- person assigned responsible and
- clear timeframes for completion of actions.

QA meeting group also discussed action plans to be used as preparations for Quality Conversations to ensure actions are agreed, timeframes set and line managers to follow up on these agreed actions.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The acting Quality Manager and Director of Service have implemented a Policy working group, which has commenced on 25/02/2020. A schedule is now in place with persons responsible and working groups to ensure completion of review of all Schedule 5 and

other SPC policies.

Since the inspection in Roseville took place a complete review of the Medication Management Policy was completed and the signed policy is now available on the Q drive and was also sent as Practice Development to all SPC staff on the 03/04/2020.

The Safeguarding Policy is currently under review by the Social Work Department. The review will be completed latest by the 20/04/2020.

The working group for review of the Restrictive Practice and Restoration of Rights Policy is currently completing the review and update of the policy, which will be completed and signed latest by the 30/04/2020.

The Communications Policy and File Retention Policy are under review with the SPC Corporate Governance Manager and will be completed by 30/05/2020.

The Policy on supporting people with personal and intimate care has been reviewed by a designated staff member. Amendments are currently under review and the working group is aiming to complete the policy by 30/04/2020.

Further update on progress regarding the review of Schedule 5 policies can be given to the inspector on an ongoing basis.

The Education, Training and Development Policy has been developed new and is currently under review to be completed and signed off.

As part of the necessary review of policies further SPC have been reviewed and signed off now:
• Capacity & Consent Policy
• Transport Policy
• Volunteer Policy

The Infection Control Policy has been updated and is now awaiting to be signed off by the CEO and a Board Member. This will be completed latest by the 15/04/2020.

Also an NG Policy is currently being prepared and under review with the Director and Assistant Director of Service.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Schedules for each persons supported weekly activities are discussed at the residents

meetings in Roseville. To ensure that changes of a persons planned activities is not impacting on their quality of meaningful day, the PPIM, PIC and Team Leader have discussed and agreed:
• All people supported to be informed if there is any change in their planned activities.
• In case an activity needs to be changed or postponed due to organizational issues alternative in house activity to be offered to the person supported.

Rosters are reviewed on an ongoing basis to ensure adequate staffing levels are in place to facilitate people's supported roles based activities.

Especially during the current COVID-19 pandemic the PIC, Team Leader and staff team are reviewing daily routine and activities for all people living in Roseville on an ongoing basis to ensure meaningful days during the times of social distancing.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Repair and painting work in Roseville are ongoing. The leak in the premises was fixed by the 29/02/2020. Maintenance has scheduled the repainting of the internal wall as soon as the area is fully dried and ready for painting works.

Painting of outside wall areas was requested by the Team Leader to the maintenance department, which is now being delayed due to the COVID-19 pandemic. The PIC and Team Leader will follow up as soon as restrictions are lifted to ensure completion of this work.

The Team Leader has requested via email to SPC maintenance department on the 30/02/2020 for handrails to be fixed in the kitchen area to provide more independence for one person supported living in Roseville. The PIC and Team Leader awaiting response and confirmation of installation.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
On the day of the inspection an oxygen cylinder was found not to be stored appropriately in Roseville.

Following actions were taken immediately after the inspection:
• The PIC contacted the GP immediately after the HIQA inspection took place to request a review for the prescription of oxygen for the person supported in Roseville.
• The review concluded that the person supported no longer requires oxygen and prescription of same has been discontinued.
• The oxygen cylinder was removed from Roseville on the 03/03/2020.
• The PIC of Roseville has requested H & S department via email on the 02/03/2020 to identify a suitable location for the storage of oxygen in Roseville in case a future need will arise for a person supported.
• The Assistant Director of Service has started previous to the inspection in Roseville to audit information relating to prescription and usage of oxygen within SPC service. An email was sent on the 24/02/2020 to all PIC's and Team Leaders to identify designated centres with stored oxygen. The aim is to identify for each person supported if prescribed oxygen is currently in use and if not to ensure reviews are completed to identify any required changes or discontinuing of oxygen.
• A Practice Development was sent out by the Assistant Director of Service on the 17/02/2020 regarding the supply of oxygen, which included guidance on stock checks and transportation.
• Immediately after the inspection in Roseville, SPC H & S department sent out an email 28/02/2020 to all designated centres requesting photographic evidence on current storage of all oxygen in SPC house to ensure correct storage of oxygen.
Also included in the email was:
- A reminder for all PICs and staff teams to use the magnetic sticker which highlights oxygen is in transit on vehicles and
- A request a review of risk assessments around storage of oxygen.
- A reminder regarding adherence to visual inspections of oxygen tanks.

• Material data sheets for oxygen tanks were sourced from the supplier by H & S department on the 28/02/2020. The data sheets will be filed with the risk assessment and Standard Operating Procedure for storage and usage of oxygen within each designated centre.
• The SPC Standard Operating Procedure for the usage and storage of oxygen was updated to include BOC, Health Care Ireland guidelines in the document. The SOP was sent to all PIC's and Team Leaders on the 03/03/2020 to ensure all staff teams have guidance around storage and use of oxygen.
• Systems of response in case of an emergency are outlined in the BOC guidelines, which are now being included in the Standard Operating Procedure and were sent to all SPC staff members on the 06/03/2020 to ensure the safe and secure handling and management of oxygen within the service.

As part of the emergency planning during COVID-19 the BOC guidelines around the cleaning of oxygen cylinders were included in an SOP and circulated to SPC staff on the 03/04/2020.

The Team Leader and PIC have also reviewed the risk register for Roseville. A new risk register log has been developed, risk assessments were updated, including lone working.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
At the inspection and also the completed provider audit medication errors, mainly counting errors of medication were identified. Medication errors had been addressed with the staff team and the previous PIC of the designated centre within team meetings.
The current PIC and Team Leader have now taken the following actions to address the counting errors with the staff team:
• Team Leader discussed mediation errors and findings of provider audit and inspection report.
• Nightly stock checks were implemented for loose medication.
• Installation of a new light in the medication area to ensure better light reduce risk of missing loose medication.
• Team Leader developed a template for stock check on Epilem medication, which is checked by 2 staff members.
• Daily stock checks to be completed.
• The PIC and Team Leader have requested a support training by the medication officer to take place in March 2020, which had to be postponed due to the outbreak of COVID-19. Team Leader to follow up and ensure training wil take place for the staff team. In the meantime support by PPIM, PIC and Team Leader in implementation of actions.
• Review of all actions been taken after 20 days.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC and Team Leader have both completed SRV training and have started to build capacity within the staff team, offering house workshops since January 2020 around roles and goals for all team members.
Review of visioning meetings for all people supported in Roseville are scheduled by the Team Leader. Based on the understanding the staff team is currently developing around roles and goals, each person's roles and goals will be reviewed. The staff team have also started to implement the Roles based planning toolkit, where re-visioning and action plans will be documented.

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.	Substantially Compliant	Yellow	06/04/2020
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.	Substantially Compliant	Yellow	15/04/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	15/04/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	30/05/2020

	kept in a good state of repair externally and internally.			
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	30/05/2020
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.	Substantially Compliant	Yellow	30/05/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment,	Not Compliant	Orange	03/04/2020

	management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	20/04/2020
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	20/04/2020
Regulation 04(3)	The registered provider shall review the policies	Not Compliant	Orange	15/06/2020

	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.			
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.	Not Compliant	Orange	30/05/2020
Regulation 05(4)(c)	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 is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's	Not Compliant	Orange	30/05/2020

	wishes, age and the nature of his or her disability.			