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:	DC1 - Praxis Care 1 (Navan)
Name of provider:	Praxis Care
Address of centre:	Meath
Type of inspection:	Short Notice Announced
Date of inspection:	19 May 2021
Centre ID:	OSV-0001907
Fieldwork ID:	MON-0032681

About the designated centre

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

The service provided was described in the providers statement of purpose, dated March 2018. The centre provided residential care and support for 11 adults experiencing a learning disability. The centre consisted of two separate, two storey dormer style houses located within a short walking distance of each other in a large town in County Meath. Each of the residents had their own bedroom which had been personalised to their own taste. There were well maintained gardens and grounds surrounding each of the houses. The centre is staffed by a centre manager, team leader and support staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Wednesday 19 May 2021	09:45hrs to 15:45hrs	Caroline Meehan	Lead
Wednesday 19 May 2021	09:45hrs to 16:15hrs	Anna Doyle	Support

What residents told us and what inspectors observed

The governance and management arrangements in place were not effective in ensuring this service was safe or appropriate in meeting the assessed needs of the residents. In addition, on the day of this inspection, inspectors found that the service was not adequately resourced and, serious issues were identified with the management of medication practices and staffing levels.

The inspectors observed that residents were not being supported to have a meaningful life and, there were ongoing and prolonged compatibility issues between them. This had resulted in the delivery of ineffective, inconsistent and unsafe services to some of the residents. These issues were further compounded due to staff shortages and, at the time of this inspection, the service was operating with a number of relief staff as there were two staff vacancies not filled. The staff skill mix also required review as the staff did not have sufficient clinical knowledge or skills to respond appropriately to residents' health care needs and identified health care related risks.

On review of a sample of files, the inspectors also noted that some mandatory training and training specific to supporting residents in the centre had not been completed by all staff. Training in emergency first aid, Feeding, Eating, Drinking and Swallowing (FEDS) and Fire safety was either not completed by some staff members, or refresher training was required. This in turn meant some staff did not have the necessary knowledge to support residents in line with their assessed needs.

The inspectors also found that one resident's right to privacy and dignity was compromised with regard to their personal care and using the bathroom. Again, this issue was due to compatibility issues between residents living in the centre.

Issues were also identified with infection prevention and control. For example, in one house hand sanitising gels were not readily available and the provider's own contingency plan was not always implemented. A review of records found that residents' temperatures were not consistently recorded, and some areas of the centre were not clean.

The systems in place to manage medicines in the centre were not safe or in line with best practice. The inspectors also found that staff's knowledge about some prescribed medicines was limited, and a number of practices observed required urgent improvement. It was also observed that the system for monitoring the supply of controlled medicines in the centre was not in line with national guidance. Because of these concerns the provider was requested to submit urgent assurances the day after the inspection in relation to some medication practices.

Over the last few months a significant number of safeguarding concerns occurring in this service had been notified to HIQA. These notifications primarily related to

compatibility issues between residents. While the provider had taken some measures to address these issues, they were not sufficient or adequate in ensuring that residents were safe in the centre. Staff also highlighted to the inspectors that residents were not safe in the centre.

In addition; while residents spoke positively about the staff, they were missing their day services they had been attending prior to COVID-19. It was evident from speaking to some of the residents and staff members, reviewing support plans, and audits of the care and support in the centre, that the closure of day services in March 2020 due to the COVID-19 restrictions had negatively impacted on the quality and safety of care and support being provided. Over the course of this inspection, residents voiced their frustration with this situation.

There were also ongoing safeguarding concerns in the centre which had escalated since the closure of day services. Most concerns were related to residents not being happy with prolonged periods of time sharing the same space with their fellow residents. The were irritated with this situation, and had become either verbally or physically aggressive towards each other as a way of communicating their frustration.

This centre consisted of two community homes which were within a short walking distance from each other. Due to current public health advice, one inspector visited one community house and the other inspector visited the other. For the purpose of this section of report and to describe what inspectors observed, and what residents told us, the houses are referred to as house 1 and house 2.

In house 1 the inspector got to meet all the residents. Some were enjoying their breakfast or a morning coffee, whilst others were still getting up when the inspector arrived.

The inspector did a brief walk around of the house while observing social distancing rules and observed that residents had their own bedrooms which had been personalised to their individual style and preference. There was sufficient communal space in the centre and one resident had an area converted into their own office space where they liked to shred paper. However, some areas of the centre required refurbishment and updating. For example; some of the flooring upstairs needed to be updated.

One resident showed the inspector their bedroom, which had an en-suite bathroom. The bedroom was personalised to the resident's taste, to include a large double bed, a computer desk and had storage facilities. This resident also spoke about what life was like living in this centre. The resident had a particular interest in music and film and showed the inspector their collection of of DVD's and CD's. The resident spoke about previous concerts they attended and how they were delighted to be able to return visiting the library to borrow music CD's. They spoke about their frustration with the restrictions imposed due to COVID-19, including not being able to attend their day service in the initial stages of the lock down and, described how they had advocated for themselves (with family support) to have part of their day services

reinstated. This resident also said that they liked living in the centre, liked the staff there and also liked that they were able to go home to visit their family.

The resident also spoke about other activities they liked to do which included going for drives, take way coffees and walking to the shops independently.

Another resident in House 1 spoke about some of their support needs and told the inspector that they were very happy and proud that they had recently given up smoking. They said they had decided to quit smoking themselves due to their own health care concerns. This informed the inspector that some residents were empowered and supported to make decisions about their care and support.

However, there were a significant number of restrictions in place and the inspector found that some of them were impacting on peoples' rights in the centre. For example; staff members informed the inspector that residents who were prescribed medications in the centre were only allowed to drink decaffeinated coffee and tea. There was no evidence to suggest that this decision included the residents own personal preferences, as it had been recommended by an allied health professional.

As already stated, due to the restrictions around COVID-19, the day services attended by residents was closed. At the time of this inspection, staff were primarily responsible for the provision of day services to residents in the centre since March 2020. While staff reported that they were doing their best to get residents out for a drive or an activity everyday, at times, it could be difficult to manage.

This was resulting in negative outcomes for residents. For example, one resident who really missed their day service and friends was spending large portions of their day in their bedroom. Another resident's records indicated that there had been an increase in their behaviours of concern which was most likely due to a lack of meaningful activities during the day.

However, residents were looking forward to reverting back to some of the activities they enjoyed once the restrictions were lifted. These included shopping, concerts, visits home, and getting to meet up with their friends for coffee. One resident had even developed a 'wish list' for when the restrictions were lifted and had plans to go on a train journey and visit 'Tayto Park'.

Staff were observed and overheard being respectful and courteous to the residents over the course of the inspection and residents appeared relaxed in their company. Staff were also observed to be respectful of the communication preferences of residents. For example, one resident used sign language to communicate support and there was a wall of signs displayed in the centre to show and act as a reminder to staff to support the resident with their specific communication style.

There were five residents living in House 2 and the inspector briefly met two of the residents during the morning. The inspector met with one resident and said they were happy living in the house and got on well with their peers. However, this resident also said there was not a lot to do during the day and they would like to go out for a coffee if possible during the day. The resident’s bedroom was comfortable and nicely decorated and had a number of personal pictures on display. Adjoining

this bedroom was an en-suite bathroom, and the resident had been provided with equipment and devices in order to support their mobility and general well being. The resident told the inspector they felt safe in the centre and could talk to the person in charge if they had any worries. The resident also said they had recently met up with their family and was really pleased with this. The inspector observed that staff promptly attended to the resident's requests for assistance, and was also supported by the person in charge.

The staff in this house were observed to be kind and respectful in their interactions with residents: however, staff spoken with highlighted that residents were not safe in the centre due to peer to peer incidents and described the environment as tense and no longer homelike. A staff member also described to the inspector the safeguarding measures that were required to be taken in order to meet one resident's basic care needs to access bathroom facilities, while trying to ensure the resident's safety was maintained. The inspector found this was not upholding the residents' right to respect or dignity.

As with the first house, the residents in House 2 had previously attended a day service; however, this option was no longer available to them. There were significant safeguarding issues in House 2 and the person in charge described how the loss of day services had resulted in increased safeguarding concerns since March 2020. The inspector found the lack of a consistent day programme and insufficient staffing had negatively impacted on the quality of life for residents, exposing them to an ongoing risk to their well being and safety.

From a walk around the centre, there were areas which required improvement. The hallway and sitting room was noted to require attention to ensure if was homely and welcoming and to ensure seating was appropriately laid out. Some maintenance had been carried out to some parts of the centre however, further work was required to be completed.

The following two sections of the report will further expand on how the lack of effective governance and management was negatively impacting on the quality and safety of the lives of residents living in this centre.

Capacity and capability

Overall inspectors found that this centre was not adequately resourced and the governance and management systems in place were not effective in ensuring residents were safe and provided with a good quality of life. Inspectors found that of the 11 regulations inspected against, 9 required significant improvements and the remaining 2 required some improvement, which resulted in negative outcomes for residents.

In January 2021, following a review of the number of safeguarding incidents being notified to HIQA, the provider was requested to submit written assurances outlining

how they proposed to address these incidents, and ensure the safety of residents living in the centre. The provider submitted a comprehensive response plan outlining the actions they were going to take to mitigate the identified risks however, inspectors followed up on these during the inspection and found that a number of key actions outlined in this plan had not all been completed.

Furthermore inspectors found that safeguarding concerns were still unresolved and there were insufficient staff on duty to ensure the safety and welfare of residents could be maintained, and safeguarding plans in place were implemented effectively. As a result the provider was issued with an immediate action to address this issue and written assurances were provided to the inspectors prior to the end of the inspection which mitigated the immediate risk. In addition, inspectors also found that medication management practices were not safe and the provider was requested to submit assurances to HIQA the day after the inspection to outline how they were addressing these practices. The details of this risk are discussed further in the next section of this report.

The centre had a defined management structure in place which consisted of a person in charge who worked on a full-time basis in the centre. There was also a team leader on duty every day (who also did the sleepover hours in the centre). This was to ensure oversight of the centre when the person in charge was not on duty. The person in charge was a social care professional and had been appointed to this post in May 2020. The person in charge reported to the head of operations, who was also a person participating in the management of this centre. They both met monthly to discuss the services provided in the centre.

The provider had conducted an annual review and six monthly unannounced quality and safety reviews as required under the regulations. The inspector looked at audits and found that they were highlighting concerns found on this inspection. For example; it had been noted in the annual review conducted in September 2020 and reviewed again in December 2020, and in the unannounced quality and safety review in April 2021, that safeguarding, medicines management, and health care planning were issues of concern. In fact, at the last unannounced quality and safety review in April 2021, 38 areas of improvement were identified, 23 of which were rated non complaint at this time by the provider's own auditor. In addition the inspectors found some of these actions were not due to be addressed in a timely manner, and as such were not being responded to appropriate to the risk presented. For example, in the six monthly unannounced visit, issues in relation to the medicine prescription sheets had an action completion date approximately four weeks after it was first identified, despite this presenting a potential safety risk to residents.

While the provider had other regular audits to review the quality and safety of care, they had not highlighted concerns such as infection control and some of the medicine management practices found at this inspection. In addition, the provider had not appropriately responded to the loss of day services for residents to ensure sufficient resources were in place, and to ensure the impact of such loss did not place residents at ongoing risk.

Given the lack of response to their own internal audit and review systems, the findings on inspection, the negative impacts on the quality and safety of residents lives, and the significant improvements required, the inspectors found that the governance and management of the centre was not effective and required significant review.

There were insufficient staff on duty to meet the needs of the residents at the time of the inspection. Since March 2020 when the day services for residents had closed, staff in the centre were now also responsible for ensuring that residents were supported with meaningful activities on a daily basis. While some additional staff had been employed in one unit daily since January 2021 and within the last two weeks in the other house, inspectors found that the levels in place did not adequately ensure that safeguarding plans could be fully implemented or that appropriate supervision levels could be provided so that risks to residents could be minimised. During the inspection the head of operations told the inspector that an additional 30 hours of staffing had recently been sanctioned in response to safeguarding concerns; however, the head of operations stated recruitment for these hours would take approximately two months. In the interim, the provider had not made arrangements to fill these hours with relief staff.

There were also two staff vacancies in house 1. On review of the staff roster over the last two months there was on average 10 - 15, 12 hour shifts per week, which were filled by relief staff. While the provider had employed a consistent relief team to fill these vacancies, this could not be sustained on a long term basis if residents were to receive consistent care

The skills mix in the centre needed to be reviewed also, as some residents in the centre had health care needs and medicines prescribed, that required review and oversight from a qualified professional. For example; after a resident had been discharged from hospital, there had not been regular oversight from suitably skilled professional, instead staff in the centre were responsible for the oversight and care of this resident's health care needs. Inspectors found that some staff were not sufficiently knowledgeable on the care and monitoring required to manage known health care risks. From speaking to the person in charge and staff, they were not always aware of some residents' health care needs and associated risks, and were not aware why some medicines were prescribed for specific health care needs.

Staff met with said they felt supported in their role and were able to raise concerns if needed with the person in charge or a team leader on a daily basis. However, some staff reported that some of the measures outlined in safeguarding plans and some infection control measures could not be implemented at all times, impacting residents' safety, wellbeing and exposing them to ongoing risks.

An out of hours on call service was also provided by senior managers in the centre. Regular staff meetings had also been held to review the care and support being provided in the centre and while staff reported that they received regular supervision these records were not reviewed by inspectors. Personnel files were also not reviewed as part of this inspection.

The training records were reviewed the day after the inspection. These records indicated that staff were required to have specific mandatory training completed. Some of this included, 'care of medication', fire safety (fire training, fire extinguishers and fire drills), emergency first aid, safeguarding vulnerable adults and positive behaviour support. The records viewed indicated that two staff had not completed emergency first aid and three had not completed fire extinguisher refresher training.

The provider had also listed training that was specific for staff to have completed to work in this designated centre, these included a medication competency assessment, moving and handling (practical and theory), epilepsy awareness training and the management of violence and aggression. The records indicated that some staff had not completed these courses or completed refresher training where required. In addition, it had been highlighted that FEDS training for all staff and supervision training for team leaders was to be completed and this had not been done by all staff at the time of this inspection. Given this, inspectors were not assured that all staff had been provided with the necessary skills to support residents and this warranted significant improvements.

The provider had prepared a Statement of Purpose for the centre which included the requirements outlined in Schedule 1 of the regulations. However, it did not include the specific staffing expertise required to assure an effective service to the residents. For example; it was not stated in the document what specific training staff required in order to support residents with their needs.

Regulation 15: Staffing

Staffing levels in the centre were not sufficient to meet the needs of the residents and to ensure residents were protected. Staffing levels had not been adequately reviewed to reflect residents' change in need relating to a lack of day service.

The provider had not ensured that staffing levels were sufficient to respond to safeguarding risks in the centre and to ensure residents were protected. There was two staff on duty during the day in house 1; however, a second staff member was not always available in the early part of the night, to ensure the required supervision levels were provided as per safeguarding plans. In house 2 there were three staff on duty during the day. One of these staff was assigned to one resident at all times. The inspectors found the availability of two staff to support the other four residents was not sufficient, due to the safeguarding measures required as described by staff, and due to two staff required for some residents with their personal care. An immediate action was issued on the day of inspection to the provider and assurances were given to the inspectors by the end of the inspection. As a result the provider made arrangements to have two staff members on duty up to 10pm in house 1, and four staff members on duty in house 2 for 12 hours during the day.

The skill mix in the centre required review to ensure that residents had access to timely input from a suitably qualified professional when required. The staff in the

centre did not have sufficient clinical knowledge or skills to respond appropriately to residents' health care needs and identified health care risks as would be provided by a suitably skilled professional.

Judgment: Not compliant

Regulation 16: Training and staff development

The training records viewed indicated that staff were required to have specific mandatory training completed. Some of this included, 'care of medication', fire safety (fire training, fire extinguishers and fire drills), emergency first aid, safeguarding vulnerable adults and positive behaviour support. The records viewed indicated that two staff had not completed emergency first aid and three had not completed fire extinguisher refresher training.

The provider had also listed training that was specific for staff to have completed to work in this designated centre, this included a medication competency assessment, moving and handling (practical and theory), epilepsy awareness training and the management of violence and aggression. The records indicated that some staff had not completed these courses or completed refresher training where required.

It had been highlighted that FEDS training for all staff and supervision training for team leaders was to be completed and this had not been done by all staff at the time of this inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The centre was not adequately resourced to ensure that residents were provided with a safe quality service. The provider had not ensured sufficient staff resources were provided, or that these staff had the required skills and knowledge to meet the needs of residents specifically in relation to residents' healthcare needs. Additionally the resources provided did not reflect the need of residents in terms of a change of day service provision, protecting residents from abuse, and compatibility concerns.

Given the significant issues identified on this inspection, the inspectors were not assured that these arrangements were effective or improving the quality and safety of care being provided. The system for monitoring quality of care and support was not resulting in improvements, and consequently residents continued to experience a poor quality of care and support.

While the provider had identified a number of concerns through audits, reflective of the findings of this report, corrective action had not been taken by the provider to

ensure risks were minimised for residents, and to ensure residents were receiving an acceptable standard of care and support.

In addition, the monitoring system did not comprehensively review or identify some aspects of care and support, specifically some medicines management practices and infection control. Some of the actions submitted to HIQA as part of a provider assurance report had not been satisfactorily addressed at the time of inspection

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a Statement of Purpose for the centre which included the requirements outlined in Schedule 1 of the regulations. However, it did not include the specific staffing expertise required to assure an effective service to the residents. For example; it was not stated in the document what specific training staff required in order to support residents with their needs.

Judgment: Substantially compliant

Quality and safety

Residents were not all being supported to have a meaningful life in the centre. There was ongoing compatibility issues between them which were leading to an inappropriate and unsafe service for some residents. Although the provider was aware of the issues, they had not taken appropriate or adequate actions to address these concerns. Significant improvements were also required with regard to personal plans, infection control, medication management, residents health care needs and with residents' rights.

The centre was for the most part clean, although some areas which included the staff shower rooms were not. Both properties needed modernisation or updating in specific parts of the centre. Some areas of the property were also not homely. For example, the entrance hall in House 2 had no furniture, pictures or soft furnishings, and the large sitting room in House 2 had a fridge in the room, with some of the seating facing a window. In house 1 a number of improvements were required to update the property. The PPIM for the centre informed an inspector that funding was available for this and a property manager had recently visited the centre to compile a list of works to be completed in the centre. This provided assurances to the inspectors that the provider was already dealing with the issues.

The provider had developed a contingency plan to prevent/manage an outbreak of COVID-19 in the centre. This included providing personal protective equipment

(PPE), ensuring that staff had been provided with training in infection prevention control and donning and doffing of PPE. However; one inspector observed that hand sanitising gels were not readily available in House 2 and the method of accessing hand sanitisers presented in itself a further infection control risk. In addition; other measures included in the provider's own contingency plan were not always implemented. For example; a review of records found that residents' temperatures were not consistently recorded. Staff also informed the inspector in one house that surfaces were only cleaned twice a day as opposed to the four times as outlined in the provider's own contingency plan. As already stated some areas of the centre were not clean and required attention also.

Notwithstanding, staff were knowledgeable about what to do in the event that a staff or resident was suspected of having COVID-19 and the provider had contingencies in place to isolate a resident should this be required. However, the non adherences to infection control best practice and the providers contingency plan, posed an additional risk of spread of infection to both residents and staff.

Some medicine management practices were reviewed during the inspection. Inspectors found that the some of the systems in place were not safe or in line with best practice guidelines. Staff's knowledge about some prescribed medicines was also limited. As stated earlier in the report because of the concerns the provider was requested to submit assurances the day after the inspection in relation to some practices. The practices observed that required improvement included the following:

- prescribed medicines had not been signed by a medical practitioner

- where a residents medicine had been changed, there was no prescription from a medical practitioner to confirm the changes required

- a prescribed medicine had been administered to a resident outside the recommended times that they were prescribed for

- a controlled medicine which is required to be checked at the handover of a shift was not being done

- the procedure for the administration of medicines to residents on a day trip was found to be unsafe.

All staff had been provided with training in safeguarding adults. Staff spoken with were aware of the procedures to follow in the event of an incident of abuse occurring in the centre. As already stated a significant number of safeguarding concerns had been notified to HIQA, which primarily related to compatibility issues in the centre. The provider had taken some measures, however, they were not sufficient to ensure that residents were safe in the centre. Staff spoken with highlighted that residents were not safe in the centre.

Inspectors reviewed residents documentation and found that residents had a personal plan in place outlining the supports they required and also included an assessment of need. However, some of the information contained in the assessments and plans had not been updated. For example; one assessment stated

that a resident attended a day service Monday to Friday, even though the resident had not attended this since March 2020 and another stated a healthcare intervention which was no longer being implemented. There was also an absence of healthcare support plans to guide the care and support to be provided. Some staff were also not clear about the needs of some residents. For example; one resident who had high cholesterol and high blood pressure, had no plan of care around the required support, and the staff member spoken with was not aware of how this was managed.

Residents had access to a range of allied health care professionals. This included GP services, physiotherapist, occupational therapist and a dentist and optician. However, inspectors were not assured that when recommendations were made by an allied health professional that they were always being recorded and implemented. For example; due to a health care need of one resident their fluid intake was required to be monitored daily however, this had not been carried out which caused a risk to the health of the resident.

Some measures were observed where residents' rights were respected in the centre, however, given the highly restrictive environment that residents lived in (particularly in house 1) inspectors were not satisfied that the residents will and preference had been considered as part of the decision to implement these restrictions.

In addition, it had been noted that residents were frustrated with the lack of day services in the centre over the last year and this continued to be an issue at the time of the inspection. In house 2 the inspector found the safeguarding measures required to reduce the risk of peer to peer incidents, impacted on a resident's basic care need to access the bathroom, and consequently their right to respect and dignity.

Regulation 17: Premises

The entrance hall in House 2 was sparsely decorated and not homely looking. Furniture within the sitting room in House 2 was poorly laid out, and a fridge was inappropriately located in this room.

Both properties needed modernisation or updates in specific parts of the centre. The provider had reviewed this and had developed a list of areas to be addressed. This included new window blinds, insulation of two bedrooms, and an upgrade specific to floors in both houses.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Suitable arrangements were not in place in relation to infection prevention and control. Staff were observed to be wearing appropriate personal protective equipment in line with public health guidelines.

Hand sanitising gels were not readily available in House 2 and the method for staff to access hand sanitiser presented in itself an infection control risk. While this measure was in place in response to a risk of ingestion, alternative methods had not been explored to ensure hand sanitiser was easily accessible, as was the requirement in the provider's contingency plan.

The provider had developed a contingency plan in response to the recent COVID-19 pandemic; however, the inspectors found the measures outlined in this plan were not consistently adhered to. For example, residents' temperatures were not consistently recorded in the centre. Surfaces were only cleaned twice a day in the centre as opposed to the four times required in the provider's own contingency plan

Some areas of the centre were not clean.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medicines management practices in the centre were not safe and were putting residents at risk of harm. Staff's knowledge about some prescribed medicines was limited. While the person in charge and staff knew what some of the medicines were prescribed for, in some cases they stated they did not know. Given the needs of the residents, the potential risks of some medicines and the staffing arrangements in the centre, the inspectors were not assured that that the level of staff knowledge was safe and appropriate.

The person in charge explained that online medicine management training was delivered by the provider and competencies of staff was assessed by the person in charge or team leaders for each staff member. While staff had received training in medicines management, some staff told the inspectors they did not feel competent to carry out medicine management procedures in the centre.

There were significant concerns regarding the prescribing practices in the centre. Most prescribed medicines had not been signed by a medical practitioner. The person in charge had outlined there had been difficulty in getting medicines prescription records signed by a prescribing doctor. A local procedure had been developed, whereby staff transcribed medicines from a prescription. However, valid prescriptions were not available for a number of medicines transcribed on medicines prescription records. Where a resident's medicine had been changed there was no valid prescription from a medical practitioner to confirm the changes required. The provider was requested to urgently address concerns regarding the prescribing

practices in the centre and assurances were provided to HIQA the day after the inspection.

Administration practices were also not found to be safe in the centre. From a review of prescription administration records inspectors found a prescribed medicine had been administered to a resident outside the recommended times that they were prescribed for this. Practices relating to the administration of medicines to residents on a day trip were not safe. Medicines were dispensed into a improperly labelled container by a team leader; however, the person responsible for the administration of medicine during a day trip had not witnessed this dispensing. Consequently the staff member was taking responsibility for ensuring the correct medicine was administered to the correct resident without having taken the correct preparation steps.

Additionally medicines administered to residents who were on day trips were not recorded as administered, and alternatively recorded as away on leave from the centre. As a result it was not clear whether resident had actually received their medicines as prescribed.

The system for monitoring the supply of controlled medicines in the centre was not in line with national guidance and a controlled medicine which was required to be checked at the handover of every shift was not being done.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors found assessments of need and personal plans were not up-to date to reflect residents' current needs and support requirements. For example, from a sample of documents reviewed, assessments and plans stated residents attended day services despite not having attended for over a year. Consequently plans had not been updated to reflect residents' current needs in the absence of day service, and to ensure a clear plan was in place for residents to meet their social care needs in this regard.

Similarly a healthcare assessment and plan was not reflective of resident's current support needs, and the inspectors found given the risks associated with a high risk medicine intervention, the changing need of this resident was not satisfactorily considered or planned for.

Judgment: Not compliant

Regulation 6: Health care

The inspectors found residents' health care needs were not comprehensively met. Residents accessed the service of a local GP and allied health care professionals were accessed by referral to the HSE.

Some health care plans were developed; however, a number of health care plans were not in place for some residents. This meant that guidance was not available for staff on how to support residents with some of their healthcare needs.

The inspectors found that residents healthcare needs were not monitored appropriately, and as a result staff could not provide assurances that residents' healthcare needs were being monitored or recorded in line with healthcare professional recommendations.

Some staff were not clear or knowledgeable about the needs of some residents and some known healthcare risks.

Judgment: Not compliant

Regulation 8: Protection

The provider had not ensured that residents were protected from abuse and responsive measures had not been taken by the provider to address ongoing safeguarding and compatibility issues in the centre.

There were ongoing incidents of peer to peer safeguarding concerns and the measures outlined in safeguarding plans were not consistently resulting in a reduction in these incidents. The provider had not completed a number of actions outlined in a provider assurance report to address safeguarding concerns in the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspectors were not satisfied that the residents will and preference had been considered as part of the decision to implement some restrictions used in the centre. The measures implemented in response to safeguarding concern impacted the dignity of a resident.

Residents were frustrated with the lack of day services in the centre over the last year and this continued to be an issue at the time of the inspection.

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 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for DC1 - Praxis Care 1 (Navan) OSV-0001907

Inspection ID: MON-0032681

Date of inspection: 19/05/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Registered Provider will re-assess all resident's needs to ensure staffing/skill mix is in line with assessed needs. Completed by 25.06.21 • The Registered Provider will ensure staffing levels are sufficient to respond appropriately to safeguarding risks in the centre and ensure protection of residents. o House 1; 2 staff on shift until 10pm each night. House 1 ; 1 waking staff 9pm to 9am o House 2; 4 staff on shift 12 hours per day. o House 2; 1 waking staff 9pm to 9am. o Team Leader completes sleep over staff (11am-11pm/7.30am -11am) This will remain under review when Day Service is re-instated. Commenced on 19.05.21 • The Registered Provider will upskill and support the retraining of all staff in relation to clinical knowledge and skills to respond to healthcare need and health care risks as appropriate. Completed by 2.07.21 • The Registered Provider has assessed the health needs of all residents, associated risks and ensured input from allied health professionals as required. Completed by 25.06.21. • The Registered Provider has recruited 5 WTE identified vacancies, to meet the additional resource requirement. The registered provider continues recruitment for 1 remaining vacancy. To be completed by 31.08.21 • The Registered Provider will recruit a registered nurse to ensure appropriate clinical governance oversight. To be completed by 1.09.21 • The Registered Provider will ensure a specific staff team is allocated to each service to ensure they are knowledgeable and accountable in the assessed needs of residents. Completed by 2.07.21.	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• The Registered Provider will ensure all outstanding mandatory training is completed as outlined :

o Care of medication: To be completed by 02.07.21
o Medication competency: Completed on 25.06.21
o Fire safety: Completed on 20.05.21
o Extinguishers: Completed on 10.06.21
o Fire drill: Completed on 10.06.21
o Emergency 1st Aid: Completed on 21.06.21
o Safeguarding Vulnerable adults: Completed on 20.05.21
o Positive Behaviour Support: Completed on 20.05.21
o Moving & Handling: Completed on 11.06.21
o Management of Violence and Aggression: Completed on 25.06.21
o Epilepsy awareness training: Completed on 17.06.21
o FEDS Completed on 17.06.21
o Supervision (TL) Completed on 28.05.21

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The Registered Provider will ensure staffing resource in place is in line with the assessed needs of residents. Completed on 25.06.21.

• The Registered Provider continues recruitment for one remaining vacancy. This vacancy is currently been backfilled by regular relief. To be completed by 31.08.21

• The PPIM will be allocated to oversee the service 5 days per week, 9-5pm and will be the Registered PIC for next 3 months and then reviewed. Commenced on 8.06.21. To be reviewed on 8.9.21

• Human Resources and the Person in Charge will meet weekly to progress any HR, recruitment matters. To be reviewed after 8 weeks. Commenced on 25.5.21. To be reviewed on 19.7.21

• Quality Assurance Manager will support the service 9-5 Mon-Friday. Commenced on 31.05.21 and to be reviewed on 30.06.21.

• The Person in Charge will report to the Provider Nominee bi-weekly for 3 months initially. Commenced on 08.06.21.To be reviewed by 07.9.21

• The Provider Nominee will visit the centre bi-weekly for 3 months initially. Commence on 8.06.21. To be reviewed by 7.9.21

• The Registered Provider has re-assessed the healthcare needs of all service users. Completed on 25.06.21

• The Registered Provider will provide appropriate support and mentoring to the staff team and ensure they are knowledgeable and skilled to meet all resident's needs. Commenced on 24.05.21.
• The Registered Provider will continue to advocate and support the residents for the reinstatement of Day Services in line with their wishes. 7 residents have recommenced day service three days per week as of the 16.06.21. 1 resident is due to return on 21.07.21 three days per week & 1 resident currently attends outreach twice weekly.
• The Registered provider will ensure a meaningful day activity schedule is in place to support residents in the absence of day service Commenced on 13.06.21
• The Registered Provider will re-audit the service in July 2021, September 2021 and December 2021 in addition to the 6 monthly unannounced judgement framework and annual review. To be completed by 31.12.21.
• Provider Assurance Report – The actions within this report have been reviewed by the Quality Assurance Manager and the Person in charge, all actions that remain applicable will be closed with the exception of the transition of one service user. Completed by 25.6.21
• The Registered Provider will continue to keep under review the monitoring system to ensure it comprehensively reviews medicine management practices and infection control. Commenced on 24.05.21.
• The Registered Provider has identified a suitable designated centre for 1 resident based on their assessed needs. The Registered Provider will transition and support the resident and their family to facilitate this move. It is anticipated this transition will occur within 7 weeks. To be completed by 6.08.21
• The Registered Provider will ensure there is a robust transition plan in place to support this transfer of one service user. To commence by 2.07.21
• The Registered Provider will recruit a Registered Nurse, who will review and oversee the application of medication standards and the meeting of health care needs of residents on a risk prioritised basis and in response to specific concerns identified through internal audit and monthly monitoring. Commence by 1.09.21
• The Registered Provider will ensure that monthly monitoring reports, undertaken by Operational Heads, are reviewed regularly and at supervisions to allow for a timely and robust discussion on any red rag rated feedback relating to safeguarding. Commenced on 1.06.21
• The Registered Provider will ensure monitoring takes place on a weekly basis at Senior Leadership Team meetings to ensure noted safeguarding concerns are appropriately managed and prioritised in a timely manner and subject to remedial action/s as required. Any trends and patterns identified will be discussed at the monthly Operational Governance Sub Group meetings. Commenced on 16.06.21
• The Registered Provider will ensure the Organisation's Safeguarding Champion monitors safeguarding concerns arising from incident reports and report to the Senior Leadership Team any material concerns on a weekly basis. Commenced on 23.06.21
• The Registered Provider will ensure that all services identified as having serious quality concerns will be subject to scrutiny by the Operational Governance Sub Group which meets on a monthly basis. Such services will also be subject to an immediate audit. In addition, the risk matrix of services is also reviewed by the Board's Care and Governance Committees. This includes all services appearing in the Organisation's Risk Matrix Top Five. These will be audited at least twice yearly and we will audit any services identified as being of concern by the Senior Leadership Team with a follow up within 3 - 5 months, the duration of follow up dependent on the degree of concern held. To commence on

1.07.21
• The Registered Provider will ensure that services with serious high risk non-compliant findings at Internal Audit will now be re-audited by the Quality & Governance Department to further confirm and validate managerial close off reports within 3 months. To commence on 1.07.21
• The Registered Provider has developed a new operational managerial induction which is being implemented in August 2021 with closer alignments with core responsibilities and contemporary Quality and Governance systems. This will be in conjunction with a Management and Leadership Programme fully developed and delivered across the organisation. To be commence August 2021.
• The Registered Provider will have an internal audit of any service with a new manager in post approximately 6 months into their tenure with a remedial action plan and re-audit put in place if required. This will be linked to confirmation in post. To commence on 1.07.21
• The Registered Provider will increase its internal audit capacity in Ireland by 1 WTE Quality Assurance Manager. To be completed by 1.09.21
• The Registered Provider will ensure the internal audit is being integrated into the Quality and Governance Management Information Framework. This will support accessibility of audit trends / themes / concerns in a live and empirical manner. The new system will allow for live data monitoring at service, regional and organisational level regarding a range of data sets, such as the detail of actions set, the person responsible and dates for completion. The new system will have inbuilt alignment of the audit KPI standards to allow immediate analysis of the findings against regulation and or good standards and their respective findings of compliant-partially compliant-not compliant. The new online system will allow for monitoring of close out and identification where any go over their close off date with inbuilt escalation occurring, in particular where non-compliant action plans go past their deadline. To commence by 30.08.21
• The system will also allow for monitoring of organisation trends / themes across all settings once audited to allow organisational learning and upstream actions where areas of concern are noted. To commence by 1.09.21
• The Registered Provider has invested in its Property Department with planned cyclical maintenance as a key area of focus. To commence by 1.10.21
• The Registered Provider is completing a full review of the Monthly Monitoring Report to include escalation and risk rating. To commence by 1.10.21

• The Registered Provider will ensure validation of actions closed in audit processes by the Head of Operations and Quality and Governance Department as required. To commence by 1.07.21

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose:	

• The Registered Provider has reviewed the Statement of Purpose to include specific training required to support residents with their assessed needs. Completed on 18.06.21

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Person in Charge has updated the cleaning schedule to ensure same is in line with policy. Completed on 14.06.21
• The PIC will ensure access to hand sanitising/handwashing in all areas of centre. Completed on 20.05.21.
• The PIC will ensure residents symptom monitoring is consistently recorded in the centre in line with National Policy. Commenced on 20.05.21.
• The Registered Provider has reviewed and updated the cleaning schedule and symptom monitoring recording in the centre to ensure this is signed off daily by the team leader. Commenced on 14.6.21.
• A deep clean of the service has been arranged. Completed on 25.06.21.
• The Registered Provider has a clear action plan and schedule of works relating to the property and upgrading the premises. All actions will be completed now Covid 19 restrictions have eased. These actions will upgrade and modernise the property. To be completed by 27.07.21.
• The service will be re redecorated taking into consideration the individual preferences and needs of service users. To be completed by 27.07.21.
• The Registered Provider will ensure the cleanliness of the centre is checked monthly in the monthly monitoring visit. Commenced on 31.05.21.
An environmental audit will be completed monthly by the PIC. Issues raised within the audit will be escalated to the Director of Care, Health and safety officer and/or Head of Property as appropriate. Commenced on 31.05.21.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The Registered Provider will complete a deep clean of the centre. Completed on 25.06.21
• An environmental audit will be completed monthly by the PIC. Issues raised within the audit will be escalated to the Director of Care, Health and safety officer and/or Head of Property as appropriate. Commenced on 31.05.21
• Further oversight of the cleanliness of the centre will be monitored in the monthly

monitoring report which is completed by the Head of Operations. Commenced on 31.05.21
• An organisational policy which is reflective of National policy is in place to guide best practice in relation to infection control practices, local procedures such as the cleaning schedule will be reviewed in line with this policy. Commenced on 14.06.21
• The PIC will ensure procedures are place to support appropriate access to hand washing/sanitising facilities in all areas of the centre. Commenced on 20.05.21
• The PIC will ensure residents symptom monitoring is consistently recorded in the centre as directed by National policy. Commenced on 20.05.21
• The cleaning schedule, daily symptom monitoring records and availability of hand sanitisers will be checked daily by team leader on duty. Commenced on 14.06.21

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The Registered Provider will provide a specific workshop to the staff team in relation to prescribed medicinal products for each service user. This will be repeated bi monthly for next 6 months. Commenced on 23.06.21. To be completed by 18.12.21
• The Registered provider will re-complete Care of Medication training with all staff. Commenced on 14.06.21 To be completed 02.07.2021.
• The Registered provider will re-complete medication competencies with all staff, this will be bespoke to the medication and needs of SU in this area. Completed on 25.06.21
• The pharmacist will provide advice, consultation, and information leaflets to ensure that staff and the individual have sufficient information for the proper use and storage of prescribed medicinal products. Completed on 25.06.21
• The Register Provider has met with the GP surgery. Medication records are signed by the prescriber, separately and in addition to the issuing of a legally valid prescription. Completed 25.06.21.
• The Person in Charge will ensure that active records are maintained in the centre at all times. Completed by 25.06.21.
• The Person in Charge has ensured the handover document now includes the check and sign off of controlled drugs and that this occurs at handover between staff shifts. Commenced 20.05.21.
• The Person in Charge has ensured the practice of administering medication for day trips is updated to ensure the administration and witness of and dispensing is performed by the same person. Commenced by 20.05.21.
• 6 monthly medication review appointments have been arranged for all residents. Completed 25.06.21.
• The Registered Provider will ensure a full medication audit by a registered nurse is completed monthly for the next 6 months and then reviewed. Commenced 29.06.21.
• Medication will be audited as part of the Registered Provider audit programme in July, September and December 2021. To be completed by 31.12.21.

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 Person in Charge and Quality Assurance Manager have reviewed all assessments and personal plans to ensure they are reflective of current assessed need and support requirements. Plans in place include the supports required to meet the individual social care needs of residents and incorporate comprehensive activity plans. A full review and development of associated plans of Health care needs has been completed following consultation with GP, allied health professionals and support of a registered nurse. Completed on the 25.06.21.

• Annual reviews for each service user have been arranged. To be completed by 31.07.21.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• The PIC and a registered nurse manager are comprehensively reviewing the healthcare needs of all residents. Completed 25.06.21.

• The Registered Provider has ensured there is a comprehensive Healthcare plan in place for all residents. Completed 25.06.21

• A workshop, overseen by a registered nurse manager has been completed with staff to ensure clear guidance is in place to support staff appropriately in meeting service users assessed needs. To be completed by 02.07.21.

• An assessment of all health needs in the centre, has been completed, risk associated, management plan and any specialist healthcare input required outlined Commenced on 25.06.21

• The PIC has confirmed with the GP the required monitoring and recording arrangements required in relation to residents' healthcare needs. The PIC will ensure these recommendations are implemented. Commenced on 03.06.21.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • The Registered Provider has completely reviewed all restrictions within the centre Completed on 14.06.21. • The Registered Provider has increased the staff resource within the centre and is closely monitoring all safeguarding. Commenced on 19.05.21. • The Registered Provider has completed a full review of the measures outlined in safeguarding plans with a view of reducing the incidents in the centre. Commenced on 20.05.21. • The Registered Provider has completed a full compatibility assessment of all residents in the centre. The outcome of these assessments will be progressed based on assessed needs. One service user will move to alternative accommodation with the support of the MDT and family. To be completed by 06.08.21. • 7 residents have recommenced day service three days per week as of 16.06.21. 1 resident is due to return on 21.07.21 three days per week & 1 resident attends outreach twice weekly. A bespoke programme of activity for residents not attending day service will be developed based on their assessed needs as current traditional day service model does not currently meet their needs. Commenced on 13.06.21. • The actions within the Provider Assurance Report have been reviewed by the Quality Assurance manager and the Person in Charge, all actions that remain applicable with the exception of the transition of one service user. Completed 25.06.21. • Safeguarding policy and safeguarding plans will be discussed at monthly staff meetings and through staff supervision. Commenced on 30.06.21.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The Registered Provider and behaviour consultant will review all restrictive practices in the centre including their impact on others living in the centre. Commenced on 14.06.21. • The Registered Provider will ensure the residents will and preference with regard to restrictions is sought and their choice incorporated in all risk management processes. Commenced on 14.06.21 • 7 residents have recommenced day service three days per week as of 16.06.21. 1 resident is due to return on 21.07.21 three days per week & 1 resident attends outreach twice weekly The Registered Provider will ensure robust activity plans are in place at all times with the centre. Commenced on 14.06.21. • The Person in Charge will ensure all staff complete human rights training. To be completed by 31.07.21. • A restrictive practice review meeting will be held in the centre monthly for the next 6 months and will include the behavioural consultant. Commenced 14.06.21 • The Person in Charge will review safeguarding plans monthly. Commenced 01.06.21. • The Person in Charge will ensure Human rights, Restrictive practices & Safeguarding will be a fixed agenda item on all staff, Team Leader and Residents meetings. Commence from 30.06.21.	

• The Person in Charge will ensure all Team leaders complete PBS training to coaching level. To be completed by 31.03.22.

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 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 size and layout of the designated centre.	Not Compliant	Red	01/09/2021
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	02/07/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	27/07/2021

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	27/07/2021
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	31/08/2021
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	01/09/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting	Not Compliant	Orange	25/06/2021

	procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
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.	Not Compliant	Red	20/05/2021
Regulation 29(4)(d)	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 storage and disposal of out of date. unused,	Not Compliant	Orange	20/05/2021

	controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988), as amended.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	18/06/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	25/06/2021
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in	Not Compliant	Orange	25/06/2021

	accordance with paragraph (1).			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	31/07/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	02/07/2021
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.	Not Compliant	Orange	25/06/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	06/08/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature	Not Compliant	Orange	31/07/2021

	of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/07/2021