Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	Silverpine House
Name of provider:	Enable Ireland Disability Services Limited
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	03 November 2021
Centre ID:	OSV-0002038
Fieldwork ID:	MON-0033899

About the designated centre

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

The designated centre is located in a town in County Wicklow. It is operated by Enable Ireland and provides planned short term day and overnight respite services on a six or seven night a week basis to children with a disability. Children availing of the service are between the ages of eight to 18 years of age, both male and female. The centre has capacity to accommodate up to five children at a time in the house. At the time of the inspection, the centre provided respite care to a total of 40 children. The centre is a detached single story building which consists of a kitchen come dining room, sitting room, a games room, a sensory room, a number of shared bathrooms, five individual bedrooms and an office. There is a well maintained enclosed garden to the rear of the centre containing suitable play equipment including a swing, roundabout and activity centre. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

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 3 November 2021	09:35hrs to 16:20hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

On the day of the inspection, there were no children staying in the respite house. For this reason, the inspector did not have an opportunity to speak with children regarding their experiences of staying in the house. The inspector used conversations with key staff, observations and a review of documentation to form a judgment on the quality of care in the designated centre. The inspector wore appropriate personal protective equipment (PPE) and maintained social distancing in line with current public health guidance during all interactions with staff. Overall, the inspector found that residents were receiving a quality, person-centred and child-friendly service which was respectful of childrens' dignity, autonomy and rights. Improvements were required to the fire precautions and risk management in the centre. These will be discussed further in the quality and safety section of the report.

The inspector observed that the designated centre was clean, bright and homely. A deep clean was taking place on the morning of the inspection. The centre was decorated in a child-friendly manner with art work displayed throughout. Each bedroom was decorated according to a theme and some offered different facilities such as a double bed or en-suite. Staff spoken with were aware of residents' preferences and assessed needs and took this into consideration in advance of allocating a room.

The children had access to a large games room, sitting room, sensory room, kitchen and garden with accessible playground. The sensory room, games room and playground were equipped with materials to support children with physical and sensory needs to engage in relaxation and play activities. Equipment observed included a wheelchair accessible roundabout, accessible swing, sensory toys and floor mats. The physical needs of residents had been considered by the provider in furnishing the bathroom and the kitchen. A height adjustable table was available in the kitchen as well as a low sink. Residents had access to a wet room with a shower and to a large accessible bathroom. The bathroom contained a ceiling tracking hoist, shower trolley and a hydrobath. Staff explained that the hydrobath was equipped with water jets, lights and music and provided an additional sensory experience for children who wished to access this. Bathrooms were observed to be clean and well maintained.

Children also had access to various technologies for relaxation and entertainment including two televisions, games consoles, internet and child-friendly subscription channels.

There was evidence that children enjoyed a range of in-house activities as well as accessing external community-based activities. A book of activities available in the community was maintained. Staff showed the inspector how they use this book at resident meetings to assist residents in planning activities. The accessibility of community venues was considered as the book noted if venues were wheelchair

accessible and what facilities were available.

Staff spoken with appeared knowledgeable regarding residents' needs and preferences. Staff were aware, for example, of the measures in place to respect residents' dignity and autonomy when they were staying in the designated centre. Where additional supports were required these were risk assessed and comprehensive care plans were in place.

The inspector reviewed the complaints, comments and compliments records on the day of inspection. It was noted that there were no complaints recorded up to the date of the inspection in 2021. There were several compliments and thank you cards which detailed that many of children and guardians were happy with the service being provided. Parents complimented the cleanliless and appearance of the house, the staff team and the measures in place to manage and mitigate against the risk Covid-19.

A sample of the parents' and young person questionnaires from 2020 were reviewed. These questionnaires were gathered by the provider in order to inform their annual review of the quality and safety of care of the service. The questionnaire responses detailed that the majority of parents valued the respite service and were happy with the care provided. The young person questionnaires set out that the majority of young people who responded felt happy and confident when staying in Silverpine House.

The next two sections of this report will present the findings in relation to the governance and management arrangements in place and how these arrangements impacted on the quality and safety of care in the centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the inspector found that the residents were receiving a quality service and that there were good local governance and management arrangements in place which supported the delivery of this service. However, improvements were required to the oversight of risk in the designated centre to ensure that this service was being provided in a safe environment. Risk management, in particular to mitigate against the risk of fire, was an area identified for improvement. This will be discussed in more detail in the quality and safety section of the report.

On the day of inspection there were two staffing vacancies for social care workers. This equated to a staffing deficit of 1.5 whole time equivalents. Staff vacancies had been identified as an area of non-compliance in previous HIQA inspections of this

centre. The person in charge (PIC) informed the inspector that the provider had made attempts to fill these vacancies however there were difficulties with finding suitable candidates. The provider had put in place arrangements to ensure that relief staff used to fill gaps in the roster came from a small panel of regular staff. This supported continuity of care for residents. A planned and actual roster was maintained. A review of the roster demonstrated that staffing allocations were in line with the statement of purpose and as per the assessed needs of residents.

The provider had systems in place to ensure that staff were suitably qualified and trained to meet the needs of residents. A training needs analysis was completed which demonstrated that staff had a high level of both mandatory and supplementary training. All staff were up-to-date in mandatory training which included fire safety, safeguarding, Children First, infection prevention and control and medication management. Many staff had completed additional training in areas required to meet the multiple assessed needs of the children accessing respite. For example, all staff had completed training in feeding, eating drinking and swallowing (FEDS) and managing behaviour that is challenging (MAPA). Several staff had also completed training in Percutaneous Endoscopic Gastronomy (PEG) feeding and oxygen management. Where training had been delivered online due to the COVID-19 pandemic, there was evidence that the provider had enhanced this learning by completing supplementary practical, in-house training.

There was evidence that regular staff meetings took place which enhanced the local oversight arrangements. A review of these minutes identified that the content was appropriate to meet the needs of the staff. Infection prevention control (IPC) and COVID-19 were included as standard items on the meeting agenda. A sample of staff supervision records were reviewed. There was evidence that staff, including the person in charge, had access to regular supervision and that where staff raised concerns during supervision, that these concerns were actioned and followed through by the PIC.

There was a clearly defined management structure in place in the designated centre. Staff spoken with were aware of their roles and responsibilities. Staff were aware of the regular staff meetings which were held twice a month online. Staff who had commenced employment in the centre in recent months reported that they felt well supported. The person in charge was supernumerary to the roster which enhanced the oversight of the designated centre. The provider had in place an on-call system in order to facilitate staff to contact management when the person in charge was not available.

An annual review and a six monthly review from within the last 12 months were available in the designated centre. These reviews set out clearly defined action plans in order to address areas which required improvements. Actions were allocated to responsible individuals and were time-bound. There was evidence that actions were followed through on. For example, one action from the provider's most recent unannounced visit was to inform the local fire officer that oxygen was stored on site. The inspector saw evidence of correspondence between the person in charge and the fire officer in relation to this action. The provider had completed a

comprehensive quality improvement plan for the centre.

A complaints policy was available in the designated centre and was found to have been reviewed recently. Staff were aware of the nominated complaints representative and there was a clearly defined process for management of complaints. The complaints procedure was on display inside the front door of the designated centre. A child-friendly, easy-to-read complaints procedure was also prominently displayed. There was evidence that the procedure for making a complaint was discussed as a standard agenda item at resident meetings. The kitchen notice board also detailed the contact details for the local advocacy service should residents require support with making a complaint.

Regulation 15: Staffing

Staffing vacancies have been identified over the course of several HIQA inspections as an area of non-compliance. There continued to be difficulties with staffing levels in the designated centre on the day of inspection with there being 1.5 whole time equivalent staff vacancies. The inspector was informed that the provider was making attempts to recruit for these positions.

Where relief staff were required, these came from a regular small panel of staff. This supported continuity of care for the residents. Nursing care was available as required and as per the assessed needs of residents.

A planned and actual roster was maintained. A review of the rosters demonstrated that staffing and skill mix were appropriate to the number and assessed needs of the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A training needs analysis had been completed by the provider. This demonstrated that all staff had a high level of mandatory and supplementary training. All staff were up-to-date in mandatory training. In many instances, where training had been delivered online, the provider had further enhanced this training by delivering supplementary, practical in-house training. In addition to mandatory training, many staff had accessed additional training in order to be able to meet the varied and multiple assessed needs of the children accessing the respite service.

Staff had access to regular, quality supervision which was appropriate to their role and responsibilities. The person in charge also had access to regular supervision. Staff meetings took place twice a month. The content of these meetings was found to address key areas such as COVID-19 and the daily running of the designated

centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place in the designated centre. Staff spoken with were aware of their roles and responsibilities. The person in charge was supernumerary to the roster and had in place mechanisms such as twice monthly staff meetings and supervisions to support enhanced oversight of the quality and safety of care. The person in charge reported to a director of services and had access to their own supervision. An annual review and six monthly visit had been completed within the last 12 months. The provider also had in place a comprehensive quality improvement plan. Action plans were in place to identify areas of need. Actions were allocated to responsible individuals and were time bound.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had put in place measures to receive and respond to complaints. An up-to-date complaints policy was in place which set out clear processes for the management of complaints. A complaints log was maintained. It was noted that there had been no complaints in 2021 up to the date of the inspection. The complaints procedure was displayed in a prominent place in the centre and had been made easy-to-read for residents. There was evidence that the complaints procedure was reviewed as a standard agenda item at resident meetings. Information relating to advocacy services was also made available to residents in the centre.

Judgment: Compliant

Quality and safety

It was clear that this designated centre provided a quality service which met the requirements of the regulations in many areas. The inspector found that childrens' rights were carefully considered in the day to day provision of this service. The provider had implemented measures to ensure that children could exercise

meaningful choices and that their dignity and autonomy was respected. Improvements were required to the provider's fire precautions and management of risk to ensure that the service was being provided in a safe environment.

A residents' guide was available in the centre. This guide was found to have been reviewed recently and contained details on the activities available, the respite user meetings, the complaints procedures, childrens' rights and information on accessing HIQA reports. The guide was written in child-friendly language.

The designated centre was operated in a manner which supported children to participate in decisions about their care and support. There was evidence that staff took measures to inform children of their rights through residents' meetings and accessible signage in key locations throughout the centre. The contact details for the local confidential recipient were displayed on the kitchen notice board. Consent forms were completed by residents and their guardians annually in relation to consent required for various support needs. Consent forms were supported by comprehensive personal plans available on resident files. Personal plans documented individual preferences and choices in relation to their support needs. They were written in person-centre language and it was clear that the child was at the centre of the plan. There was evidence that staff used a variety of multi-modal communication methods to support residents to make choices. These methods included Lámh and pictures.

Children had access to multiple facilities in the centre and externally in the community for recreation. Many children reported in questionnaires commissioned by the provider that the respite house was supportive in facilitating them to develop and maintain friendships. There was evidence that there was continuity of educational goals between school and the designated centre with childrens' educational goals being captured on their assessment of need.

A sample of resident files was reviewed by the inspector. This review identified that each child had a comprehensive assessment of need which had been updated within the last 12 months. Residents had access to health care and allied health professionals as required. Where support plans were in place these were written in a respectful manner. There was evidence that staff had reviewed these support plans and had signed off on having read and understood them. Staff spoken with were aware of residents' assessed needs.

A child safeguarding statement was in place which identified the centre's designated officer and deputy designated officer. Staff spoken with were aware of who the designated officer was. All staff in the centre had completed safeguarding and Children's First training. Consent forms were available on resident files where restrictive practices were in place. These restrictive practices were found to be supported by a comprehensive assessment of need which detailed why restrictive practices may be required. For example, if a child required a visual monitor at night-time, it was set out that the camera was to be directed only towards the child's feet to ensure they were positioned safely and were not at risk of falling.

Intimate care plans were up-to-date for those residents who required them. Staff

spoken with could describe measures they took to ensure that residents' privacy and dignity were respected in the provision of intimate care. There was evidence that where safeguarding concerns had been identified that these had been referred to the relevant authorities for investigation and notified to the Chief Inspector in line with the requirements of the regulations.

The premises of the designated centre was an older building with the person in charge reporting that it was over 100 years old. In spite of its' age, the premises was observed by the inspector to be very well maintained both internally and externally. The provider had made repairs to external plasterwork as they had committed to doing in a previous compliance plan. The building was wheelchair accessible with ramps to the front door and back garden. Internally, all rooms were observed to be in very good condition. Bathrooms were also in an excellent condition and were equipped with equipment required for use by residents. The provider had recently further enhanced the accessibility of the building by adding a ramp from the games room directly to the playground.

The registered provider had implemented measures to protect residents against the risk of acquiring a healthcare associated infection. The premises was found to be clean and tidy. An infection prevention and control (IPC) improvement plan was in place in the centre. This plan identified areas requiring improvement and an action plan was put in place to implement required changes. Staff spoken with were knowledgeable in relation to IPC. Staff were observed socially distancing and wearing masks. There was an up-to-date COVID-19 contingency plan in place. All staff had completed training in hand hygiene, IPC and PPE. Online training had been further enhanced by in-house practical training. For example, hand hygiene audits and practical assessments were completed following hand hygiene training.

The provider had taken measures to mitigate against the risk of fire however these measures were found by the inspector to be insufficient. The provider had fitted self-closing mechanisms to all internal doors however, on the day of inspection, two fire doors were found to be ineffective to mitigate against the risk of fire. One fire door leading to a bedroom did not close fully when the self-closing mechanism was activated. The door leading into the games room also had a large gap evident at the top of the door which rendered the fire door ineffective. While these were recorded on the centre's risk register, the risk was classified as low (green). Given that these doors would be ineffective in preventing the spread of smoke to a bedroom, it was considered by the inspector that this risk should have been rated higher. There was also evidence that the risk of fire doors not closing correctly had first been added to the centre's risk register in 2015. Therefore this risk had not been addressed in a timely manner.

The provider had recently commissioned an expert fire safety assessment of the building. This report was made available to the inspector. The report detailed several actions which should be taken by the provider as a matter of urgency in order to mitigate against the risk of fire. These actions included upgrading the fire alarm system, adding smoke detection to the externally located utility and boiler rooms, installing emergency lighting on escape routes, replacing ineffective fire doors and fire stopping the corridor to bedrooms. These risks had not been added to

the centre's risk register at the time of inspection.

There was evidence of good local knowledge in relation to fire procedures. Staff spoken with were aware of the procedures to be followed in the event of fire. Staff informed the inspector that fire evacuation is discussed as a standard item at the beginning of night shifts. All staff were up to date in fire safety training. There were clearly documented procedures to be followed in the event of fire and staff had signed off on having read these procedures. Fire evacuation procedures were displayed throughout the centre. Individual personal evacuation plans were in place for residents.

Day and night-time simulated fire drills were carried out regularly and a matrix was maintained which documented which staff had participated in drills. However, improvements were required to the simulation of night-time drills. Simulated night-time drills provided for mattress evacuation of one resident only. The inspector was informed that on any given night there could be up to three residents, two of whom may require mattress evacuation. Given the issues identified in the expert fire safety assessment, the inspector was therefore not assured based on these fire drills that all residents could be safely evacuated in a reasonable time frame in the event of fire. An urgent action was issued on the day of inspection and the registered provider was required to provide assurances that there were adequate arrangements in place to evacuate all persons in the event of fire. The registered provider submitted an urgent compliance plan response as required on 08 November 2021. This response detailed that a fire drill had been completed which was reflective of the actual number of residents who require mattress evacuation. The provider gave assurances that this fire drill had demonstrated that all residents could be evacuated in a timely manner.

Improvements were required to the oversight of risk in the designated centre. A risk register which was reviewed on the day of inspection was found to not be comprehensive. A more comprehensive risk register was submitted to the inspector following the inspection. A review of this risk register identified that while this risk register was more detailed, the risk ratings applied to the risks required updating in order to be more reflective of the actual presenting level of risk. For example, the risk of fire doors not closing correctly was risk rated as low (green). However, as detailed above, this risk was considered by the inspector to be considerably higher given the findings of the provider's expert fire assessment.

The inspector saw evidence of several individual risk assessments for known risks in relation to residents. For example, risk assessments were in place in order to mitigate against risks of falling from bed for individuals who were known to present with these risks. Risk assessments were also in place for several risks in the designated centre such as the storage of oxygen and the risk of COVID-19. However many of these risks were not recorded on the risk register which was furnished to the inspector on the day of inspection.

Regulation 13: General welfare and development

Residents had access to many in-house and community opportunities for recreation and play. A wide variety of activities was available depending on the child's interests, capacities and developmental needs. Residents reported through the provider's questionnaires that the main benefits of attending the designated centre was to develop friendships and individual confidence. Continuity of educational goals across services was supported by comprehensive assessments of need and care plans.

Judgment: Compliant

Regulation 17: Premises

The premises was in a good state of repair both internally and externally. It was designed and laid out in a manner which met the aims and objectives of the respite service. Residents had access to large, accessible bedrooms and bathrooms as well as facilities for recreation, relaxation and activity. These facilities were maintained in an excellent condition and were furnished with specialist equipment, appliances and toys to meet the needs of the residents. Bedrooms were clean and suitably decorated. The premises was decorated in a child-friendly manner.

An external courtyard with table and chairs was available to residents as well as a large, accessible playground. The designated centre adhered to best practice in promoting accessibility by providing a height adjustable kitchen table, lowered kitchen sink, ramps for easy access and egress and an accessible bathroom. Recent alterations had been completed to compliment the accessibility of the designated centre. These alterations included adding a sensory room and a ramp from the games room to the playground.

Judgment: Compliant

Regulation 20: Information for residents

A residents' guide was available for residents which met the requirements of regulation 20. The guide was written child-friendly language.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk assessments were in place for many individual risks however these were not reflected on the risk register which was provided to the inspector on the day of inspection. A more comprehensive risk register was provided to the inspector subsequent to the inspection. This risk register demonstrated that some known risks, such as the failure of fire doors to close effectively, had been known to the provider for several years but had not yet been addressed. Furthermore, the risk register did not accurately reflect the fire risks as outlined in the recently commissioned expert fire safety report. There was evidence that the risk register was not being used as tool to accurately identify risk and to drive quality improvement in implementing measures to mitigate against known risks in a timely manner.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had adopted procedures consistent with the standards for the prevention and control of healthcare associated infections. An up-to-date COVID-19 contingency plan was in place. The provider had also implemented a quality improvement plan for IPC which set out clearly defined actions. Staff had completed several online trainings in the area of IPC and these were enhanced by further in-house practical assessments and demonstrations. Staff spoke with were knowledgeable in relation to their roles and responsibilities for IPC. Staff were observed socially distancing and wearing appropriate PPE. The centre was clean and tidy and a deep clean was taking place on the day of inspection.

Judgment: Compliant

Regulation 28: Fire precautions

Improvements were required to the measures in place to mitigate against the risk of fire and to detect and contain fires, as well as to safely evacuate all persons in the event of fire.

The expert fire safety assessment report reviewed by the inspector identified the following areas which should be addressed as a priority by the provider in order to mitigate against the risk of fire:

- Upgrade of fire alarm system to an L1 system
- add smoke detection systems to the utility and boiler room and attic voids

- install emergency lighting on internal and external defined escape routes
- firestop corridor to resident bedrooms - recommended to sub-divide the corridor with fire doors and to treat timber linings with specialist paint
- replace ineffective fire doors

Additionally, the inspector was not assured by the arrangements in place to ensure that all persons could be safely evacuated in the event of fire. An urgent action was issued on the day of inspection in relation to fire evacuation procedures. The provider demonstrated through their urgent compliance plan response that a fire drill had been completed which was reflective of the actual number of resident staying in the designated centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need was available for each resident on the selection of resident files reviewed. This assessment of need had been reviewed within the last 12 months and was completed by an appropriate health care professional. A personal plan, written in a person-centred manner, detailed the supports required by residents and clearly documented their individual preferences. There was evidence that reviews of personal plans were completed in consultation with residents and their guardians.

Judgment: Compliant

Regulation 6: Health care

Resident files detailed access to a variety of health and allied health care professionals as required by residents. Up-to-date support plans were available for each assessed health care need.

Judgment: Compliant

Regulation 8: Protection

The registered provider had safeguarding measures in place to protect residents from all forms of abuse. A recently reviewed child safeguarding statement was available. Consent was documented on resident files for support with care needs. These consent forms were reviewed annually. Staff could describe how they ensure

residents' privacy and dignity is respected in relation to the provision of intimate care. All staff had completed safeguarding and Children First training. There was evidence that where safeguarding concerns were identified that the national guidance for the protection and welfare of children and the relevant statutory requirements were complied with.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that respected the rights of the children accessing it. The provider had measures in place to ensure that residents' choices and preferences in relation to their care and support needs were clearly documented. Guardian and resident consent to various activities and supports was formally documented and reviewed annually. Staff could demonstrate how they support residents to make choices on a day to day basis using a variety of multi-modal communication methods. Residents were clearly consulted with and participated in the organisation of the centre during their stay.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Silverpine House OSV-0002038

Inspection ID: MON-0033899

Date of inspection: 03/11/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: We have ongoing advertisements online and across social media platforms. Enable Ireland have a recruitment committee recently established which the PIC is involved in. This committee is tasked with reviewing challenges to recruitment and working on improving our recruitment policies, how best to reach the appropriate cohort of people aiming to improve the uptake on advertised jobs. The PIC continues to link with local colleges and has been a guest speaker in 1st year and 4th year Social Care workers courses to promote Enable Ireland and specifically Silverpine House to new and upcoming graduates with the hope to attract new recruits.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: On in depth review of our risk register will take place with the Health and Safety competent person and PIC to review how information is inputted and kept updated. Old risks will be archived appropriately. Regular meetings will take place to ensure this is maintained throughout the year and updated whenever changes occur. A refresher course for the Health and Safety competent person will take place on how to input risks onto the risk register, and attended by PIC in January 2021 A new risk register Matrix will be complied as a quick reference to risks in place and when updates are required. The risk register contains environmental and non environmental/clinical risks.	

Personal risks relating to individual children will be kept on personal care plans and not on the risk register in line with GDPR.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Quotes will be sought for upgrading fire doors and appropriate doors to be sourced by PIC. A schedule of works is in place throughout December and January for works to be completed. PIC to arrange upgrading of fire alarm system and additional fire alarms in utility and boiler room to be installed by 6th January.

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.	Substantially Compliant	Yellow	31/01/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Red	23/12/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate	Not Compliant	Red	06/01/2022

	arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	06/01/2022
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	06/01/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	06/01/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	23/12/2021