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:	The Willows
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	05 October 2021
Centre ID:	OSV-0002394
Fieldwork ID:	MON-0033898

About the designated centre

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

The Willows is a designated centre operated by St Michael's House located in a suburban area in Dublin city. It provides community residential services to seven residents, both male and female, over the age of 18. The designated centre is a two storey house and adjoining apartment. The house accommodates six people and consists of a sitting room, kitchen/dining area, quiet room, a staff sleep over room or office, a bathroom and six individual bedrooms (four of which are en-suite). The apartment accommodates one person and consists of two bedrooms (one of which is en-suite), bathroom and kitchen with a living area. The centre is located close to amenities such as shops, cafes and public transport. The centre is staffed by a person in charge, nurses and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Tuesday 5 October 2021	09:40hrs to 17:35hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet all residents on the day of inspection. Some residents chose to interact more with the inspector while others preferred to continue with their daily routine. The inspector wore a face mask, maintained social distancing and followed good hand hygiene procedures during all interactions with residents and staff. The inspector used observations, conversations with residents and staff, as well as a review of documentation to form a judgment on the quality and safety of the service that the residents were receiving.

The inspector observed that the residents appeared comfortable in their home. Residents were observed freely accessing most areas of the house. There was a locked half-gate to the kitchen which prevented residents from accessing the kitchen unsupervised. This locked gate had been identified as a restrictive practice and had been approved by the provider's positive approaches to monitoring group. Other restrictive practices that were in place had also been notified and approved by the positive approaches to monitoring group. These will be discussed further in the quality and safety section of the report.

On the morning of inspection several residents were still in bed. Staff informed the inspector that some residents chose to go back to bed after they had their intimate care and medication needs met in the morning. Later in the day, some residents were observed leaving the centre on outings supported by staff. These outings were to the community or to visit family. Other residents were observed enjoying the garden, engaging in music with staff, relaxing in their bedrooms or the sitting room. Some residents chose to visit the inspector in the staff office throughout the day and appeared comfortable and relaxed with having a visitor in their home.

The inspector was informed that the provider's day services had been closed due to COVID-19 but that they were reopening on a phased basis. One resident had recommenced their day service on a full-time basis. Another resident had recommenced day service two days per week. Day services for other residents had not yet resumed.

The house was observed to be generally clean and tidy. Staff were seen wearing face masks and maintaining social distancing where possible. Staff and resident interactions appeared to be relaxed. Staff spoke to residents in a gentle manner. Staff were observed interacting positively with residents, offering them support when required and engaging in activities such as playing music with residents. Staff were also observed providing assistance with mealtimes. Staff spoken with appeared to know residents well.

Resident bedrooms were observed to be decorated nicely and were personalised. The living area was homely and contained items for relaxation including a TV, DVDs, sensory lights and a bubble column. There was some painting required to common

areas. This will be discussed further in the quality and safety section of the report.

One resident lived in a self-contained apartment attached to the house. The apartment was connected to the house via a keypad locked door and had it's own external entrance. The inspector briefly met the resident living in the apartment and observed that they were being closely supported by staff who appeared to know them well. The resident refused the inspector access to the apartment on the day of inspection and so it was not possible to comment on this part of the premises.

Overall, the inspector found that residents in this house appeared relaxed and comfortable and were being supported to enjoy a good quality of life.

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

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.

The inspector was not assured on the day of inspection that there were appropriate management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. The provider's audits failed to self-identify areas for improvement in the centre. There was a lack of oversight of the centre as demonstrated by the high levels of non compliance found on this inspection. There was evidence that there was insufficient oversight of staff development, training and supervision. This was correlated to the fact that the person in charge had a significant remit whilst also working front line hours.

The provider had recently increased the whole time equivalent staffing levels of the designated centre. However, on the day of inspection, there were three staffing vacancies. A review of the rosters demonstrated a reliance on a high number of agency and relief staff in order to cover staff vacancies, annual leave and sick leave. The reliance on agency and relief staff did not ensure continuity of care for the residents. On the day of inspection, there was one agency staff on day shift and another agency staff scheduled for night duty.

There was a full-time person in charge in place. There were also two deputy managers who reported to the person in charge and supported them in the management of the designated centre. However it was reported, and recorded in staff rosters, that the majority of these staffs' working time was allocated to front-line service provision with very limited management hours. This had an impact on

the supervision and oversight of training requirements of staff.

A training matrix was not maintained in the designated centre. It was requested at the start of the inspection but was not available until the late afternoon. The training matrix demonstrated that several staff required both mandatory and refresher training in key areas. These areas included managing behaviour that is challenging, safeguarding vulnerable adults, COVID-19, epilepsy and safe administration of medications. Given the complex needs of the residents who lived in this house, there was the potential for this lack of training to have a significant negative impact on residents' lives. For example, one resident's behaviour support plan detailed that staff should use strategies as set out in a specific training programme called TIPS. On the day of inspection only three out of the 17 staff on the roster had up-to-date TIPS training. This meant that staff were ineffectively trained in order to fully implement the resident's behaviour support plan and may have been providing support in a way that was not in line with best practice.

A review of the supervision records showed that staff supervision, for both the front-line staff and the person in charge, had not taken place in line with the provider's policy. Most staff had completed only two supervisions since January 2021 while the person in charge had one formal supervision during this time frame. While a planned and actual roster were maintained, there were two copies of the actual roster for October 2021 in place. Both copies differed slightly. This contributed to confusion with staff reporting that they must check both copies or clarify with management to be sure of their allocated shifts. It was therefore unclear what the assigned whole-time equivalent was for each day or if the correct number of staff in order to provide care had been allocated.

While the provider had made improvements in relation to the governance and management arrangements of the centre by appointing a full-time person in charge, two deputy managers and increasing the staffing whole time equivalents, it was not clear that these improvements had been sustained or had contributed to an enhanced oversight of the service. An annual review was not available for the inspector to review until approximately 4.00pm on the day of inspection. This review was requested at the start of the day however staff had difficulty accessing it and were unsure of the content of the annual review. This demonstrated that the annual review was not considered a working document and was not used to enhance and drive quality improvements in service provision. The annual review, while stating that it was completed in consultation with residents, did not reflect their feedback.

A quality enhancement plan in place for the designated centre was found to be incomplete with several sections left blank. The inspector was informed that staff meetings should take place approximately every six to eight weeks however the records showed that only two house meetings had taken place in 2021, one in March and another in May. Minutes were kept of these however it was not clear if there were actions identified from these meetings and who, if anyone, was responsible for following through on these actions. Overall this demonstrated that monitoring tools available to, and used by, the provider were not identifying all areas for improvement or where change was required it was not actioned within a

time-bound plan and allocated to a responsible individual.

A copy of policies and procedures as set out by Schedule 5 of the regulations were maintained in the designated centre. However, many of these were out of date and were not the most up-to-date versions of the policies. These policies were however used as working documents with evidence that staff had signed off on them in 2021. This meant that staff may not have been providing care in line with the provider's most current policies.

A review of the statement of purpose found that it contained much of the information as prescribed by Schedule 1 of the regulations. The whole time equivalent of staffing however required amending as it was not an accurate reflection.

Regulation 15: Staffing

It was not clear that there were sufficient staff to provide continuity of care to the residents. There were three vacancies at the time of inspection. The roster detailed a significant reliance on relief and agency staff. This did not support continuity of care for residents and did not ensure that the staff providing support were always skilled and trained to cater for individual residents' assessed needs.

There were two copies of the actual roster maintained for October. Both differed slightly. Staff reported that this can be confusing and that they may need to clarify their shifts with management. This demonstrated poor oversight of the staff working arrangements which could potentially result in the incorrect staffing levels being applied to the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff supervision was not carried out quarterly as set out by the provider's policy. Most staff had accessed two supervision meetings since January 2021. The person in charge had completed only one formal supervision meeting.

A training matrix was not maintained in the designated centre. It took several hours for one to be provided to the inspector. The training matrix, when reviewed, detailed significant training requirements, this further evidenced the poor oversight arrangements in place. Deficits in training, on the day of inspection, included:

- Fire safety: eight staff required this
- Managing behaviour that is challenging: 13 staff required this
- Safeguarding: five staff required this

- COVID-19: 10 staff required this
- First aid: 12 staff required this
- Evacuation aids: eight staff required this
- TIPS: 14 staff required this
- FEDS: eight staff required this
- Epilepsy: 10 staff required this
- Safe administration of medication (SAMS): nine staff required this
- Children First: eight staff required this

Judgment: Not compliant

Regulation 23: Governance and management

Overall it was demonstrated the provider had failed to effectively implement monitoring tools and management systems to ensure the service was effectively managed and that residents were being provided with a safe and quality service.

The provider demonstrated a failure to self-identify key issues such as ineffective fire evacuation procedures and inadequate arrangements to mitigate against the risk of residents contracting a healthcare associated infection. Furthermore the centre was not adequately resourced to meet the needs of residents.

In addition there were failings in relation to information governance such as incorrect policies, inconsistencies with rosters, pertinent information such as the centre's training matrix and annual review not being readily available in the centre which demonstrated that they were not being used to ensure a safe service was being provided.

The designated centre was not resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. There were three staffing vacancies on the day of inspection and a reliance on agency and relief staff to meet the daily staffing requirements.

While there was a defined management structure in place, there were insufficient management hours allocated to ensure that the service was consistently and effectively monitored. A copy of the annual review was not kept in the designated centre and staff were unaware of the content of this review. This demonstrated that the annual review was not considered to be an essential document in monitoring the quality of care and in driving service improvements. The annual review was not comprehensive. Where actions were identified, these were not time-bound or allocated to a specific individual. For example, the annual review set out that a review of the rosters had been completed and the action arising from this stated that a recruitment campaign for staff was ongoing. There were no identified actions to address staff shortages in the interim and no time-frame for these shortages to

be addressed within. A quality enhancement plan was found to be incomplete with several sections left blank.

Staff meetings had not taken place as regularly as planned. Where these meetings had taken place, the minutes did not reflect actions arising and a SMART plan for addressing these actions was not in place.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed and was found to contain much of the information as required by schedule 1 of the regulations. However, the whole time equivalent of staffing allocation was inaccurate and required amending.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies as set out in Schedule 5 of the regulations were available in the designated centre. However, many of these policies were out of date. It was clear that staff were using these as working documents as there was evidence of staff signing off on them in the last 12 months. This meant that staff may not have been receiving the most up-to-date information or providing care in line with provider's most recent policies.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the residents appeared to be happy and comfortable in their home and that their immediate needs were being met by staff. However, the inspector was not assured that the residents were receiving a quality and safe service. In particular, improvements were required in the areas of protection against infection and fire precautions.

The designated centre was observed to be generally clean and tidy. The kitchen was well-stocked and dinner was seen to be cooking in the slow cooker. The dinner smelt and looked appetising. Staff spoken with were aware of how to modify foods and fluids in line with residents' feeding, eating, drinking and swallowing plans.

There was some general painting required in the premises, in particular to the kitchen half-wall, kitchen ceiling and the visitors' room. There appeared to be insufficient storage in the centre with hoists and wheelchairs being stored in the hallway. This did not contribute to a homely feeling**.** The sitting room was noted to be equipped with a TV, DVDs, sensory lights and a bubble column. Several residents showed the inspector their bedrooms. Their bedrooms were observed to be personalised and decorated in line with individual tastes. One resident's bed was noticed to be very low to the ground. Staff informed the inspector that this was the residents' preference in order to allow for independence in getting in and out of bed. Bathrooms and en-suites were observed to be generally clean and free of clutter.

The inspector was unable to enter the apartment attached to the designated centre on the day of inspection as the resident living their refused the inspector access. It was not possible therefore to make a judgment on the quality and safety of this part of the premises.

The designated centre had in place several procedures to reduce the risk of residents acquiring a healthcare associated infection. These included staff wearing face masks, staff engaging in good hand hygiene practices, temperature checks at the door and a log of contact details of visitors to the centre. However, improvements were required to the planning and risk assessments to mitigate against the risk of an outbreak of a healthcare associated infection in the centre. The designated centre's risk assessment for COVID-19 was found to be out of date. A COVID-19 contingency plan was in place, however there was no evidence that this was up-to-date as it was not dated. Additionally, this contingency plan self-identified that there would be a risk to the centre in the event of an outbreak due to staffing levels. There were no identified actions in the COVID-19 contingency plan to mitigate against this risk. Finally, a significant number of staff had not completed training in COVID-19.

While the provider had some arrangements in place to protect residents, staff and visitors from the risk of fire, the arrangements were not wholly adequate. As a result an urgent action was issued to the provider on the day of inspection in relation to regulation 28, fire precautions. The inspector was not assured that all residents could be safely evacuated in the event of a fire, particularly with the night-time staffing arrangements and the use of agency staff who were untrained in fire evacuations. The arrangements for supervision of residents once evacuated also required review. Additionally, several self-closing mechanisms on the doors throughout the designated centre did not function correctly, including the door to the utility room which was located in the main corridor beside several resident bedrooms. This would present a significant risk to residents in the event of a fire in the utility. Several fire doors were observed to have been repaired. It was not clear that the materials used to repair these doors were sufficient to withstand a fire and that these materials did not compromise the structural integrity of the fire door.

The person in charge took measures on the day of inspection to provide assurances regarding the night-time staffing arrangements. Assurances were given that all agency staff would be walked through a night-time fire drill. The provider also submitted a comprehensive urgent compliance plan following the inspection which

set out time-bound actions to address the identified non-compliance in relation to fire precautions.

Risk management policies and procedures were found to be in place at the designated centre with some required improvement noted. A risk register was in place for the centre which recorded several areas of potential hazard and reflected the level of risk. However the risk register did not capture all risks in the centre in particular in relation to fire and infection prevention and control, as described above. Incident logs were maintained of all accidents and incidents. There were individual risk assessments on resident files for identified risks. These were found to be up to date and written in a person-centred manner.

A review of a sample of resident files demonstrated that some assessments of need were up to date while others were in the process of being reviewed. The person in charge was aware of assessments of need which required updating and was working with staff to address these gaps. Care plans, where completed, were written in person centred language and in a respectful manner. Care plans detailed access to a range of multidisciplinary supports including opthalmology, speech and language therapy and psychology. There was evidence that My Life planning meetings had taken place in recent months however these were not all fully completed. The inspector was informed that progress on these plans is ongoing. There was evidence that where residents refused certain medical interventions that their rights were respected and additional supports were implemented in order to support decision making. For example, when a resident refused a vaccination, a social story was implemented to help the resident understand the vaccination process.

A sample of resident files reviewed identified that positive behaviour support plans were up-to-date and had been reviewed in the last 12 months. Positive behaviour support plans were written in person centred language and detailed both proactive and reactive strategies in order for staff to respond to behaviours that are challenging. There were up-to-date risk assessments in place for managing behaviour that is challenging. Staff spoken with were aware of resident needs in relation to challenging behaviour. However most staff were out of date in training in behaviour support and in TIPS. This meant that staff may not have been able to provide behaviour support interventions to residents that were in line with best practice. There was evidence that restrictive practices had been approved and were monitored by the provider's Positive Approaches to Monitoring Group (PAMG).

Staff spoken with were aware that there was a designated officer to who they could report concerns regarding abuse. Staff could not name the designated officer but were aware that there was a poster in the centre with details on how to contact this person. As set out in the earlier section of capacity and capability, some staff were out of date in training in safeguarding vulnerable adults and Children First. Intimate care plans were reviewed as part of residents' My Life meetings however at the time of inspection some residents' My Life meetings were incomplete and so intimate care plans were not up to date. For example, one resident had a My Life planning meeting in July 2021. The section to review safety, physical and intimate care on this review was not completed.

Regulation 17: Premises

The centre was observed to be well decorated with some minor painting required in high traffic areas such as the kitchen and where shelving had been removed in the visitors' room. Hoists and wheelchairs were stored in the corridor which did not lend to a homely feel in the centre. There did not appear to be sufficient storage to store this equipment as required by Schedule 6 of the regulations. Resident bedrooms appeared to be decorated in line with individual preferences**.** The inspector was unable to enter the apartment on the day of inspection and so it was not possible to make a judgment on this part of the premises.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A risk register was maintained in the centre however this risk register did not accurately capture all risks within the centre in particular in relation to fire precautions and infection prevention and control. Some risk assessments were found to be out of date.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Staff were observed adhering to standard precautions. There was evidence that temperature checks and a log of visitor contact details were maintained in the designated centre. However, improvements were required to the planning and risk assessments in place to mitigate against a potential outbreak of a healthcare associated infection in the designated centre. Finally, a significant number of staff had not completed training in COVID-19 with 10 staff requiring this.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to ensure that all

residents could be evacuated in a timely manner in the event of fire. Fire drills, particularly night-time drills were not completed within an appropriate time-frame. Staff were unclear on the measures required to supervise residents once evacuated in spite of one resident's personal evacuation plan setting out that there is a risk of this resident following staff back in to the building. The arrangements for containment of fires were inadequate with several fire doors failing to close fully. Several doors had been repaired in a manner which could compromise their integrity. Staff had not received suitable fire training with eight staff requiring training in this. Measures were not in place to ensure that agency staff who were regularly relied on to complete the staffing roster had received suitable training.

The person in charge provided assurances on the day of inspection in relation to the training of agency staff on night-duty in fire evacuation procedures.

The registered provider submitted an urgent compliance plan response following the inspection which set out measures to be taken in order to address the non-compliances identified. The urgent compliance plan set out timely objectives with all actions to be completed by the 1st of November.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Not all resident files reviewed had an up-to-date assessment of need and care plans in place. Where these plans had been completed they were written in person-centred language and detailed comprehensive supports required to maximise residents' personal development. The person in charge was aware of assessments of need which were out-of-date and had a plan in place to update these. Assessments of need detailed access to multidisciplinary supports as required.

Judgment: Substantially compliant

Regulation 6: Health care

A review of a sample of resident files demonstrated that residents had access to a wide range of medical and multidisciplinary supports as required. There was also evidence that where residents refused a medical intervention that this wish was respected and that, where appropriate, additional supports were put in place to assist residents in understanding medical interventions.

Judgment: Compliant

Regulation 7: Positive behavioural support

A sample of positive behaviour support plans reviewed identified that they were up-to-date and written in person centred language. Staff were aware of residents' behaviour support plans and could describe how they implement them. Staff were seen supporting residents in a manner which was in line with their behaviour support plans on the day of inspection.

Restrictive practices had been approved and were monitored by the provider's positive approaches to monitoring group.

However, a significant number of staff required training in managing behaviour that is challenging and in TIPS. 13 staff required training in managing behaviour that is challenging. 14 staff required training in TIPS.

Judgment: Substantially compliant

Regulation 8: Protection

Improvements were required to the area of protection in the designated centre. Five staff required training in safeguarding vulnerable adults and eight staff required training in Children First.

Intimate care plans were in the process of being reviewed as part of My Life meetings. However, from the sample of files reviewed it was noted that several of these planning meetings were ongoing for several months and the review of intimate care plans was incomplete.

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	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Willows OSV-0002394

Inspection ID: MON-0033898

Date of inspection: 05/10/2021

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: In response to non compliance under regulation 15.1 Roster review to review the WTE and skill mix carried out with administration manager, PIC, Service Manager and HR manager on the 6/10/21 with a follow up review carried out on the 13/10/21. WTE identified as 18.2 The registered provider will continue to source experienced staff to fill vacancies within the designated centre. Ensuring 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 In response to non compliance under regulation 15.3 The registered provider will ensure that all agency, relief and new staff receive appropriate induction, to ensure that they can provide safe and effective care for residents. The provider has linked with agencies to ensure that as much as possible the same agency staff are employed to cover vacancies within the centre, this will allow consistency and continuity of care while the recruitment process is ongoing. In response to non compliance under regulation 15.4 there is now a planned and actual roster in place only.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In response to non compliance under regulation 16.1(a) the person in charge has reviewed all training records and set a training plan for each staff member, with all mandatory online training to have been completed by the 24/11/21. The person in charge has liaised with the training department and requested dates for in person training and these will be scheduled in line with COVID restrictions and public Health	

guidance.

In response to non compliance under regulation 16.1(b) the person in charge has a schedule of support meetings in place. With clear actions identified in the support meetings. All staff received a support meeting in October and have one more scheduled this year, keeping the centre in line with the registered provider's supervision policy. Schedule has been provided to staff team.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In response to non compliance under regulation 23 (1) (a) a roster review to review the WTE and skill mix was carried out with the administration manager, PIC, Service Manager and HR manager on the 6/10/21 with a follow up review carried out on the 13/10/21. WTE 18.2

The registered provider will continue to source experienced staff to fill vacancies within the designated centre. Ensuring 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

In response to non compliance under regulation 23 (1) (c) the Person in Charge has been allocated two management days per week on the roster. This will be reviewed each quarter by the PIC and service manager to ensure the PIC is receiving enough management hours

There is a schedule of management meetings in place between the PIC and service manager for the remainder of the year where any issues relating to staffing, risk management, service users, and health and safety will be discussed, minutes will be taken and SMART actions recorded. Meeting held on the 27/10/21

The person in charge has a schedule of support meetings in place. With clear actions identified in the support meetings. All staff received a support meeting in October and have one more scheduled this year, keeping the centre in line with the registered provider's supervision policy.

The provider will carry out a second unannounced 6 monthly audit before the end of the year with a clear SMART action plan completed with identified actions from the audit

In response to non compliance under regulation 23 (1)(c)The PIC and service manager have populated a new regulation based QEP, with all actions from internal audits, HIQA inspections, hygiene audit, and unannounced 6 monthly provider audits included.

Monthly data reports in place and sent to service manager for review every month

Staff meetings have been scheduled for the remainder of year to be held every 6-8

weeks. Minutes will be taken and SMART actions set out. Staff meeting held on the 4/11/21.

In response to Regulation 23(1) (a) The registered provider has established a service improvement team, consisting of the director of operations, Director of Adult Services, Administration manager, Director of Quality and safety, Service manager and Person in Charge.

The purpose of the Service Improvement Team is to ensure the safety of all residents and that all actions are completed as indicated within the compliance plan. Terms of reference have been set out and the first meeting was held on the 3/11/21. The team will meet weekly initially then bi monthly once significant actions have been achieved. Minutes will be taken and clear SMART actions will be set.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
In response to non compliance under regulation 4(2) the most up to date schedule 5 policies are now in place in the designated centre with all staff aware of how to access them. Sign of sheet in place for staff to sign to confirm they have read policies.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In response to non compliance under regulation 17(1)(b) the hoists and equipment have been removed from the hall and stored in an appropriate place that will allow easy access for staff and residents when required.

Quotes for painting works have been sought with the works to be completed by 30/03/22

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In response to non compliance under regulation 26 (1) (a) All risk assessments have been reviewed by the person in charge and updated where necessary including risk assessments related to fire and infection prevention control.

In response to non compliance under regulation 26(2) The centre Risk register has been updated to include all identified risks within the centre.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection

against infection:
In response to non compliance under regulation 27 the person in charge has reviewed and updated all COVID risk assessments. The COVID centre plan has been reviewed.

The registered provider carried out a hygiene audit of the designated centre on the 19/09/21, report sent to the PIC and service manager and the PIC is in the process of implementing the actins from this audit.

All staff will have completed COVID training by the 24/11/21

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In response to non compliance under regulation 28(3)(a)

• The door closer on the utility room door as of the 07th of October 2021 has been adjusted and is now closing. Completed by Hollyfort services

• The utility and adjoining door was replaced on the 22/10/21

• LD1 addressable fire alarm system in place for early warning and live night on duty to respond immediately to avoid delay in evacuation

• The Person in Charge has included the continued non use of laundry facilities at night which is a high risk time. The continued implementation of this reduces the fire risk in this room to as low as is reasonably practicable.

• The lobby room to the flat adjacent is used as a visitor room and due to COVID restrictions there is a limited amount of materials and ignition sources within this space as such reducing the risk to as low as is reasonably practicable. This prevention plan is read, signed off and implemented by agency staff.

In response to Regulation 28 (3) (d)
• The PIC has identified Head Quarters and all personal evacuation plans and House Fire plans have been reviewed and updated.

In response to Regulation 28(4)(a)
• All permanent staff have completed the on line fire prevention training

• The Registered Provider and Person in Charge are scheduling regular block booked relief and agency staff in the next fire training for the centre

• The Person in Charge/PPIM/shift leader will complete a walk through with all relief staff and record on a fire drill form which commenced on the 7th October and remains ongoing.

In response to regulation 28(4)(b)
• The Person in Charge carried out a planned night time fire evacuation drill on the 6th October 2021 within the centre

• The Person in Charge has completed a fire prevention plan including night time which is the highest risk.

• The Person in Charge has reviewed the house evacuation plan. Clearly identified secondary building has been updated within the fire evacuation plan.

• The Person in Charge has reviewed each individual residents PEP to include each residents specific needs where relevant within a fire drill.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
In response to non compliance under regulation 5(1)(b) all assessments of need and support plans have been reviewed and are now in date.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In response to non compliance under regulation 7 (1) The person in charge has identified who requires PBS training with all training to be completed by the 24/11/21

In response to non compliance under regulation 7 (2) Ten staff have now received TIPs training with the remaining staff to be scheduled for training by the 24.11.2021

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In response to non compliance under regulation 8(6) all intimate care plans have been reviewed and updated if necessary in line with resident's personal plan and preferences.

My Life meetings for all residents have been scheduled and will take place by the 31/12/21

In response to non compliance under regulation 8(7) all staff will complete safeguarding vulnerable adults training and children's first training by the 24/11/21.

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	Orange	31/05/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/05/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	09/11/2021

	showing staff on duty during the day and night and that it is properly maintained.			
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	Red	24/11/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/03/2022
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	31/05/2022
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Red	09/11/2021

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/12/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	26/11/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	26/11/2021

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	26/11/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	26/11/2021
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	26/11/2021
Regulation 28(4)(a)	The registered provider shall make	Not Compliant	Red	26/11/2021

	arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	26/11/2021
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Not Compliant	Orange	09/11/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health,	Substantially Compliant	Yellow	09/11/2021

	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.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	24/11/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	24/11/2021
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that	Not Compliant	Orange	31/12/2021

	respects the resident's dignity and bodily integrity.			
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	24/11/2021