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:	Graifin House
Name of provider:	The Rehab Group
Address of centre:	Dublin 18
Type of inspection:	Unannounced
Date of inspection:	25 November 2021
Centre ID:	OSV-0002636
Fieldwork ID:	MON-0034843

About the designated centre

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

This community based residential centre provides a high support residential service for adults with Prader-Willi Syndrome (PWS). Each individual has complex needs in relation to their PWS, pertaining to food, behaviour that challenges, and mental and physical difficulties. The house is a two-storey, six bed roomed building located on a main road in a suburban area in Co. Dublin. Residents can also access the building from a side entrance. A large garden area is available to the front and side of the premises. Each resident has their own single room with one located on the ground floor and four on the second floor. The house is close to a broad range of services and amenities, with a public transport system also locally available. There is capacity for five residents and they are supported over the 24 hour period by care support workers, team leaders and the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 25 November 2021	09:30hrs to 16:30hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and as such, the inspector followed public health guidance throughout the inspection. This centre is home to four adults with complex support needs. Overall, the inspector found that residents were receiving good quality care and support in line with their assessed health and social care needs. However, there were a large number of safeguarding incidents occurring between residents in addition to residents having difficulties with the physical layout of the centre. Both of these issues were noted to be having a negative impact on the quality of life of the residents in the house. There were complaints from residents requesting a change in their living environment due to these incidents. This inspection identified mixed levels of compliance in the regulations inspected against and these findings are outlined in the body of the report.

On the day of the inspection the inspector had the opportunity to meet with two of the residents. One of the residents was at home with their family while another was in their day service. Two out of the residents attended a day service between two and five days a week. One of the residents was actively looking to attend a day service which had ceased due to the government restrictions in 2020. The person in charge was in communication with the HSE in order to secure funding for the resident to do so. Residents enjoyed attending a social club which was mostly taking place virtually due to public health guidance. Another resident did not choose to engage in activities on offer. Staff had sourced a class for them in an area of interest which they were attending on occasion.

In the house, there was a gym which each of the residents used each day as part of their health care programmes. There was a large sitting room/ dining room area with a television. There were photographs on the walls and trophies which one of the residents showed the inspector they had won for bocce. There was a room outside in the garden which was suitable for residents to use for a relaxation space. This was also suitable to use for family visits and counselling sessions. The house was located on a busy road in a Dublin suburb and was within walking distance of a Luas stop, enabling residents to have easy access to a number of local amenities. Residents also had access to a vehicle in the centre. Residents had two pet guinea pigs which they cared for. These were located in the sitting /dining room area.

On arrival to the centre, the inspector was greeted by one of the residents. They told the inspector that they no longer wished to live in the house and wanted to live in a bungalow. They told the inspector that the stairs was becoming increasingly difficult for them to manage. They did not have a day service at the time of the inspection, which the person in charge was actively trying to source. They reported that they wanted to have an individualised service. The person in charge spoke with the inspector and the resident. They told the inspector and the resident about what was currently being done in an effort to access a day service and to change their

living environment. This is detailed later in this report.

Later on in the afternoon, the inspector got to meet a second resident. They were enjoying typing on their laptop. The resident told the inspector that they found it difficult to live in the house as there were compatibility issues between other residents. They reported that this upset them. The resident told the inspector that they found the stairs difficult to manage. The inspector observed the resident climbing the stairs and it was observed to be very difficult for the resident. They showed the inspector their bedroom. While they had enough space to store their belongings, the carpet required replacement and the wallpaper was peeling. The person in charge told the inspector that this was budgeted for in the following years' budget.

There was only one restriction in this centre which was a locked kitchen. There was a clear rationale for this restriction. It was documented, regularly reviewed and discussed with residents. This was applied for the least amount of time possible, with residents accessing the kitchen with staff present. The complaints log was viewed by the inspector. It was evident that residents were actively encouraged and supported to make complaints. Complaints were clearly documented, logged and actioned as appropriate. Most of the complaints were made by residents in relation to their living situation - both the physical access issues in relation to the stairs and ongoing compatibility issues.
From what residents told us and from what inspectors observed, it was clear that staff were endeavouring to provide person-centred care which was tailored to each residents' specific health and social care needs. Residents were in receipt of good health care and were active participants in their home. Interactions between staff and residents were found to be supportive, respectful and kind. The premises and ongoing compatibility issues between residents was having a negative impact on the residents' quality of life. The next two sections of this report present the inspection findings in relation to the governance and management of the centre and how governance and management arrangements affected the quality and safety of the service being delivered.

Capacity and capability

The provider had strong management structures, systems and processes in place to ensure the care of residents was safe and of good quality. There was a clear management structure in place, with the person in charge reporting to the integrated service manager who in turn reported to the regional operations officer. There were emergency governance arrangements in place and these were displayed for staff. The provider had carried out six monthly unannounced visits and an annual review of the quality and safety of care in the centre, as required by the regulations. The annual review included consultation with residents and their family members. Family members were mostly complimentary of the service received and in particular, of the staff. Another family member raised the issue of the stairs being

difficult for their relative to manage.

The person in charge was full time and had suitable qualifications and experience to carry out the role to a high standard. The inspector found the person in charge to have very good knowledge of residents and their needs. They worked split shifts in the centre five days a week in order to ensure adequate oversight and support was available to staff. Residents were seen to engage with the person in charge about any queries they had. The person in charge was supported by two team leaders.

The person in charge met with other persons in charge in the region twice a month. These meetings involved the sharing of information and resources, which the person in charge reported was very helpful to them in their role. There were country wide person in charge forums once a quarter. In addition to these supports, there was a meeting with all managers in the region (including persons in charge) twice a month. The person in charge was in daily contact with their manager and formal supervision took place once every quarter. Staff meetings took place once a week in the centre and had a set agenda.

The person in charge maintained oversight over different aspects of residents' care and of the safety of the centre through audits on areas such as health and safety, residents notes, daily chores lists, medications, risk management, safeguarding, restrictive practices, maintenance and finance. These were carried out by the team leaders and reviewed by the person in charge on a monthly basis. To ensure that all relevant policies, guidance and other key information were read by all staff, the person in charge monitored staff signatures and directly communicated gaps with staff which they needed to complete. There was a clear induction plan for any agency or relief staff coming to a shift in the centre.

The provider had resourced the centre with an appropriate number of staff with the skills required to support this group of residents. Actual and planned rosters indicated minimal use of relief or agency staff, enabling continuity of care for the residents. Where relief were required, the centre had two regular staff assigned to them.

Staff training and development had improved since the last inspection. Staff had completed mandatory training on fire safety, safeguarding, food safety and a number of courses related to infection prevention and control. Training on supporting people with behaviours of concern was also completed. Specific training on Prader-Willi Syndrome had been provided to staff and where new staff had joined the team, this information was made available to them while they awaited the online session. The person in charge had a clear record of staff's training needs and courses attended. Where there were refresher training sessions due, these were booked in. Training was a standing item on all supervision meetings to ensure staff were aware of their obligations. Staff supervision was occurring every two months. A sample of supervision meeting notes was viewed by the inspector and these indicated that they were clearly documented with targets, personal development goals, service goals and achievements discussed. Supervision sessions were documented to reflect actions required , persons responsible for these actions and they were time bound. Performance management conversations took place once a

year. The staff who the inspector spoke with reported that they felt very well supported in their roles.

Complaints were well managed in the centre. The provider had a complaints policy in place and an easy to read version was available to residents who required this format. Complaints were clearly documented and it was evident that following incidents, residents were offered the option to complain if they wished to do so. There was a record of the status of complaints and whether they were resolved. Many of the complaints related to compatibility issues between residents and residents stating that they wanted to live elsewhere. Another resident indicated that they wanted fighting to stop and that they were upset by it. Other complaints related to the stairs and the access issues relating to it. Residents present on the day of inspection told the inspector that they were happy they could talk to staff about any of their concerns and felt they were listened to.

Regulation 14: Persons in charge

The person in charge was full time and had the required experience and qualifications to carry out the role. They were in the role under a year and had put good systems in place to drive quality improvement in the service. The inspector found them to have very good knowledge of the residents and their needs and was advocating on their behalf in relation to the housing situation and access to day services.

Judgment: Compliant

Regulation 15: Staffing

The inspector viewed the planned and actual rosters for the weeks prior to the inspection. They were well maintained and indicated minimal use of agency staff. There were two regular relief staff used, which promoted continuity of care which was particularly important for this group of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had made significant improvements in staff training and development since the last inspection. Training records were viewed by the inspector and indicated that all staff in the centre had completed mandatory training. A clear record of all training attended was kept by the person in charge and reviewed

frequently to ensure all staff remained in date with required training. Training was also a standing item on supervision agendas. Supervision was taking place regularly with a structured agenda in place. Minutes were action and time bound.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider had a good management structure in place. There were strong processes and systems in place to ensure good oversight over the quality and safety of care which residents were receiving. The provider had done an annual review which included consultation with residents in addition to six monthly unannounced visits in line with the regulations. There were emergency governance arrangements in place which were easily accessible to staff.

The person in charge worked split shifts in order to ensure oversight of the centre with all groups of staff. They had strong systems in place in relation to audits and documentation. Team leaders carried out audits in a number of areas such as residents' noted, daily chores lists, medication, petty cash and restrictive practices. The person in charge had provided clear guidance for staff in how to complete audits. They signed off on weekly audits and carried out monthly audits. There were a number of management meetings taking place , both at regional and national levels to ensure sharing of information and resources across services.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy in place and an easy to read version had been made available to residents. It was evident that residents were encouraged and supported to make a complaint where they wished to do so. A complaints log was kept outlining whether complaints were resolved to the satisfaction of the complainant and what staff they were at.

Judgment: Compliant

Quality and safety

It was evident that the person in charge and the staff team were endeavouring to provide a person-centred service to residents to best support their needs. This was

being done in a difficult environment due to a combination of factors such as ongoing government restrictions, poor compatibility and the premises being unsuitable for residents. The inspector found that interactions between residents and staff were respectful and kind. Residents spoke highly of the staff and the support they got.

Each resident had an annual review carried out and care plans were developed in line with identified needs. These were regularly reviewed and updated to reflect any changes for residents. Personal plans reflected the uniqueness of each resident and goals were set with keyworkers and reviewed with residents at key working sessions. Some residents had accessed third level programmes and previously enjoyed volunteering and playing sports. Much of this had been curtailed due to the COVID-19 restrictions. Each residents' will and preference were sought in relation to different aspects of their care and support.

Residents in the centre had complex health and behaviour support needs. Residents had an annual medical check with their GP. Residents had access to a number of health and social care professionals such as a behaviour therapist, a dietitian, a social worker and a counsellor. They had monthly sessions with a dietitian and a contract between each resident and the dietitian was in place in relation to their diet and exercise. Individual menu plans were provided and strictly adhered to. Residents accessed National Screening Programmes. Their right to refuse medical intervention was respected. For one resident who refused a recommended intervention, this was clearly documented and risk assessed. Documentation reflected the resident's right to make an informed decision. Consent for COVID-19 vaccines was sought and documented.

Positive behaviour support plans were very detailed and gave clear guidance to staff on proactive and reactive strategies to support residents. Guidance was given on different situations which residents may face and how best to support them in each of those situations. The restriction for the kitchen was clearly documented and regularly reviewed with MDT input. A conversation was held regularly to explain the medical reasons for this restriction and where possible, residents accessed the kitchen with staff and were supported to make meals in the kitchen where they expressed a wish to do so. Residents signed these plans.

There had been a significant number of safeguarding incidents which had taken place in the months prior to the inspection. These were largely involving two residents who had been identified as incompatible for a number of years by the provider. These incidents had increased both in frequency and intensity and as previously stated, were having a negative impact on all of the residents' quality of life in the centre. The inspector found that any safeguarding concerns were appropriately documented, reported, investigated and plans put in place. Staff were aware of how to report any concerns. Personal and intimate care plans were viewed and found to be person-centred and respectful of residents' rights, dignity and bodily integrity. However in spite of safeguarding plans that were in place, these incidents continued to occur frequently and some of the control measures such as sourcing a day service were not in place on the day of the inspection.

On the day of the inspection, the inspector found the premises to be clean and tidy but was in a poor state of repair. It was no longer suitable for all of the residents due to the difficulties previously outlined in managing the stairs. The provider had completed works required to repair a crack in the vacant room since the last inspection. However, many of the areas identified on this inspection were identified in inspections since 2015 and had also been identified by the provider in their audits. The person in charge had completed a comprehensive audit of the property and the works required. Downstairs, much of the flooring was worn and required replacement. The kitchen had chipped counter tops. Areas of paintwork required attention throughout the house such as the panelling in the hallway, skirting boards. In two of the bathrooms, there was an odour coming from the drains and some fittings required replacement due to being rusty. Mould was found on the ceiling of the downstairs bathroom and there were cracked tiles. Some radiators in the centre also required repair or replacement. One of the residents' bedrooms carpet was ridged due to wear and tear and presented as a falls risk. The wallpaper in their bedroom was also slightly torn. There were suitable arrangements in place for waste and laundry management in the centre. The premises was also recognised by the provider as being a "barrier" to addressing the ongoing safeguarding issues in the centre. The inspector viewed ongoing correspondence between the provider and a housing association in order to source alternative accommodation for residents. The person in charge was actively seeking suitable properties to view and had a clear list of requirements to best meet the needs of the residents.

The inspector found that risks were appropriately identified, assessed and managed in the centre. The provider had a risk assessment and management policy in place which contained all of the information required by the regulations. Any adverse incidents were documented and reported on the provider's online system. A clear analysis of incidents took place along with trending and learning was identified and shared at staff meetings. The risk register was clearly laid out with high risks easily identifiable for the centre and for individual residents. Risks were regularly reviewed and assessments amended as required. Risk assessments related to COVID-19 were updated to reflect changing public health guidance and restrictions.

Appropriate measures were in place in relation to infection prevention and control (IPC). This was an unannounced inspection and on arrival, the inspector found there to be appropriate procedures in place for visitors such as hand sanitiser, a temperature check, sign in sheet and questionnaire. IPC audits were taking place weekly with clear actions discussed with staff at staff meetings. Enhanced cleaning schedules were in place and observed to take place during the day. There were two identified infection prevention and control champions in the centre. There was a COVID-19 governance structure in place and clear contingency planning. The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. Up to date information and guidance in relation to COVID-19 was available for staff and discussed with residents at their forum meetings. The inspector observed staff wearing PPE appropriately and routinely sanitising their hands and surfaces. While the governance and management arrangements were

strong in addition to staff adhering to required practices, the premises required significant attention and this did not ensure that the risk of transmission of infection was managed.

The provider had fire safety management systems in place. However, these were not adhered to. On the day of the inspection there were three fire doors wedged open. An urgent action was issued to the person in charge and these were removed. Detection systems were in place in addition to emergency lighting and fire fighting equipment. There was evidence of testing, servicing and maintenance of all equipment and this was in date. All residents had personal emergency evacuation plans. These were discussed with residents and signed off. Drills took place as per the provider's schedule and used different scenarios. They were clearly documented and outlined any issues that arose. On a recent night time drill, it was noted that one of the residents had locked themselves into their bedroom. In order to open the door, staff were required to go downstairs to the kitchen area to retrieve a key and unlock the door. Two of the residents used medication to help them sleep and one had to go down the stairs on their bottom to evacuate safely. Evacuation had taken over ten minutes. A risk assessment had taken place but did not provide adequate assurance on managing this situation safely. The control measures required additional consideration and action to ensure that all residents could be evacuated safely in the event of a fire.

Regulation 17: Premises

The premises was clean and tidy but needed significant maintenance work carried out. Most of this work had been identified by the person in charge and were on a maintenance log. Many issues were outstanding since inspections commenced in 2015 such as the bathrooms. In addition to works required, the premises was no longer suitable for two residents who were having difficulties with the stairs due to their changing physical needs.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector found that risks were appropriately identified, assessed and managed in the centre. The provider had a risk assessment and management policy in place which contained all of the information required by the regulations. Any adverse incidents were documented and reported on the provider's online system. A clear analysis of incidents took place and learning was identified and shared at staff meetings. The risk register was clearly laid out with high risks easily identifiable for the centre and for individual residents. Risks were regularly reviewed and assessments amended as required. Risk assessments related to COVID-19 were

updated to reflect changing public health guidance and restrictions.

Judgment: Compliant

Regulation 27: Protection against infection

Appropriate measures were in place in relation to infection prevention and control (IPC). This was an unannounced inspection and on arrival, the inspector found there to be appropriate procedures in place for visitors such as hand sanitiser, a temperature check, sign in sheet and questionnaire. Enhanced cleaning schedules were in place and observed to take place during the day. The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed and was regularly reviewed. Up to date information and guidance in relation to COVID-19 was available for staff and discussed with residents at their forum meetings. The inspector observed staff wearing PPE appropriately and routinely sanitising their hands and surfaces. A temperature log for residents and staff was kept and done twice each day. While the governance and management arrangements were strong in addition to staff adhering to required practices, the premises required significant attention and this did not ensure that the risk of transmission of infection was managed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had fire safety management systems in place but these were not appropriately adhered to. On arrival to the centre, the inspector noted three wedges keeping fire doors to the office, sitting room and dining room open. An urgent action was issued to the person in charge and these were removed. Drills took place as per the provider's schedule and used different scenarios. They were clearly documented and outlined any issues that arose. On a recent night time drill, it was noted that one of the residents had locked themselves into their bedroom. In order to open the door, staff were required to go downstairs to the kitchen area to retrieve a key and unlock the door. Evacuation had taken over ten minutes. A risk assessment had taken place but did not provide adequate assurance on managing this situation safely. Two of the residents used medication to help them sleep and one needed assistance in getting down the stairs. This, in addition to the resident locking their door required additional consideration and action to ensure that all residents could be evacuated safely in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had an annual review carried out and care plans were developed in line with identified needs. These were regularly reviewed and audited regularly to ensure they reflected any changes for the resident. Personal plans reflected the uniqueness of each resident and goals were set with key workers and reviewed with residents at key working sessions. Some residents had accessed third level programmes and previously enjoyed volunteering and playing sports. Much of this had been curtailed due to the COVID-19 restrictions.

Judgment: Compliant

Regulation 6: Health care

Residents had an annual medical check with their GP. Residents had access to a number of health and social care professionals such as a behaviour therapist, a dietitian, a social worker and a counsellor. They had monthly sessions with a dietitian and a contract between each resident and the dietitian was in place in relation to their diet and exercise. Individual menu plans were provided and strictly adhered to. Residents accessed National Screening Programmes. Their right to refuse medical intervention was respected. For one resident who refused a recommended intervention, this was clearly documented and risk assessed and respected the right of the resident to make an informed decision. Consent for COVID-19 vaccines was sought and documented.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans were very detailed and gave clear guidance to staff on proactive and reactive strategies to support residents. Guidance was given on different situations which residents may face and how best to support them in each of those situations. Where there was one restrictive practice in place which was the kitchen being locked, this was clearly outlined to residents. A conversation was held regularly to explain the medical reasons for this restriction and where possible, residents accessed the kitchen with staff and were supported to make meals in the kitchen where they expressed a wish to do so.

Judgment: Compliant

Regulation 8: Protection

A significant number safeguarding incidents had taken place in the months prior to the inspection. These mostly involved two residents who had been identified as incompatible for a number of years by the provider. These incidents had increased both in frequency and intensity and as previously stated, were having a negative impact on all of the residents' quality of life in the centre. The inspector found that any safeguarding concerns were appropriately documented, reported, investigated and plans put in place. Staff were aware of how to report any concerns. Personal and intimate care plans were viewed and found to be person-centred and respectful of residents' rights, dignity and bodily integrity. However in spite of safeguarding plans that were in place, these incidents continued to occur frequently and some of the measures such as sourcing a day service were not in place on the day of the inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Graifin House OSV-0002636

Inspection ID: MON-0034843

Date of inspection: 25/11/2021

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 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider intends to take a two stage approach to addressing the issues of concern raised in this inspection report: short / medium term actions will be taken in the first instance and this will be followed by the implementation of a long term plan to fully reconfigure the service delivery.

Senior operational management met with the housing association on 06/01/2022 to make decisions in relation to how to address the current unsuitability of the premises to meet the existing resident's needs. The following actions were agreed:

1. Commence property search for 2 bedroom ground floor apartment in the close geographical area to Graifin House to accommodate 1 resident who has expressed the will to live alone. PIC has developed a brief for the search and submitted it to the property department on 11/01/2022. Property department have commenced the search. The HSE has requested a costing for the proposed service. Currently a full costing is being developed for the running of this service. This will be completed and submitted to the HSE on 21/01/2022 and discussed at the meeting with the HSE on the same date.

2. The Housing Association's Officer tasked with the Graifin House project visited the property on 14/01/2022 to conduct an assessment and determine the feasibility of re-organising the ground floor in order to accommodate the needs of residents who struggle with the stairs. Options that were assessed include repurposing downstairs rooms to bedrooms and the installation of a stair lift. Following the assessment, options will be provided for the senior management team and a decision will be made on how to progress. It is expected a decision will be made by 31/03/2022.

3. Following the assessment by the Housing Association a report will be supplied to senior management to determine if a long term solution would be to complete large scale renovation works on existing premises or progress with the purchase of an alternative property to accommodate 3 residents. It is expected that this decision will be

made by 31/03/2022.

It is anticipated that issues related to property will have been resolved by June 2023.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Urgent remedial works will be completed by 30/06/2022: these include painting and kitchen and bathrooms renovations.

During the visit on 14/01/2022 an assessment of the above works was completed. The extent of the works to be completed will be influenced by the longer term plan for re-configuration of the service.

In addition, a deep clean of the service was completed by an external company on 18/01/2022.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Wedges have been removed from the service, all staff have been reminded that wedges are not to be used to hold fire doors open. Completed on 25/11/2022.

• A quote for 7 maglocks for each fire door downstairs has been obtained by PIC and approved by housing association. Works to be completed by 31/01/2022.

• Local night evacuation plan will be updated to include the use of an emergency lanyard containing all residents' bedroom keys. Sleep over staff will take lanyard with them when they retire for the night. In place as of 20/12/2022.

• PIC will meet with the 2 residents who refused to evacuate during night drill and reinforce the importance of prompt evacuation when the fire alarm sounds.

• Options for fire training for residents are currently being explored.

• A repeat night time fire drill will be completed in Q1 2022.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• PIC and PPIM meet with HSE on 14/12/22 and options for day service for relevant resident were discussed, HSE are due to meet with the resident to offer a day placement on 20/01/2022.

• In conjunction with Behaviour Therapist options for day activities led by staff on a 1:1 basis with relevant resident are currently being explored with the resident while the resident is awaiting day service placement. This process commenced on week starting 13/12/22.

• Behaviour Therapist continues to provide support to staff team and residents. Two residents also regularly access support from the Psychology Service.

• A meeting with the HSE is scheduled for 21/01/2022 to escalate the urgency of review of current living arrangements for all residents and presentation of the costings for a single living unit for one resident.

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Red	30/06/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	30/06/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by	Substantially Compliant	Yellow	30/06/2022

	adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/01/2022
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	31/12/2021
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.	Substantially Compliant	Yellow	31/12/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of	Not Compliant	Red	30/06/2023

	abuse.			