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:	Carriglea Residential Service
Name of provider:	Carriglea Cáirde Services
Address of centre:	Waterford
Type of inspection:	Short Notice Announced
Date of inspection:	18 May 2022 and 19 May 2022
Centre ID:	OSV-0003509
Fieldwork ID:	MON-0033238

About the designated centre

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

The statement of purpose currently details that the service provides care for 29 adult residents, both male and female with a primary diagnosis of intellectual disability. The service supports residents with high support needs, based on age related and physical dependency, mental health, autism and behaviours that challenge. The staff team is composed of nurses and care assistants. There is a good staff ratio with a minimum of one or two waking night staff in all houses. Admissions to this centre are accepted from those persons already living in the registered providers community houses, who may require additional clinical and staff supports. The accommodation comprises of five individual houses located close together on a large site in a coastal town. There is sufficient communal space, kitchens and bathrooms available for the residents. There are a number of day services attached to the organisation in the local community and an activities centre and swimming pool on the grounds of the centre. At the time of the inspection there were 26 residents living in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

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
Wednesday 18 May 2022	12:00hrs to 18:30hrs	Lisa Redmond	Lead
Thursday 19 May 2022	09:00hrs to 15:30hrs	Lisa Redmond	Lead
Wednesday 18 May 2022	11:30hrs to 18:30hrs	Conor Brady	Support
Thursday 19 May 2022	09:00hrs to 15:30hrs	Conor Brady	Support

What residents told us and what inspectors observed

This large designated centre comprised of five houses, referred to by the staff as 'units', located on a rural campus based setting.

During this two day inspection, inspectors met with 24 of the 26 residents that lived in the designated centre. Inspectors spoke with residents, staff members providing care and support to residents in their home, and members of the organisation's senior management team. It was evident that staff members provided supports to residents in a kind, caring and respectful manner, and that residents were safe and cared for in their homes.

However, inspectors also found that a number of aspects of this centres design, layout and operating care practices were institutional in nature. These practices were observed to be in keeping with a medical model of campus based care and the collective management of people as opposed to being individualised, person centred and/or rights based.

For example, the use of a campus canteen whereby food was delivered to and from 'units' from a centralised kitchen (as opposed to bought and prepared with residents and cooked in their own homes). A campus laundry saw large blue 'laundry trolleys' continuously coming/going from the 'units' as opposed to residents clothes being washed in their own homes. Large medication trolleys moving up and down 'units' (sometimes to administer a very small amount of medicine). A hair salon was in one unit rather than the residents being supported to access and use their local community salon. Staff were observed moving throughout and across all units on campus (sometimes without knocking or ringing door bells) which gave no sense of residents having individual homes and was observed as a very institutional and ward based approach to care.

The residents' homes themselves were all located in close proximity to each other, in a congregated setting. The gardens and surrounding areas were expansive and very beautiful, with residents having access to a nearby forest walk. However, it was observed that some parts of the premises themselves including residents' accommodation were out-dated and not in a good state of repair. The provider had plans to de-congregate the centre which had been delayed due to the COVID-19 pandemic. Some of the buildings dated back to the 1940's and were not observed to be homely nor suitable to resident's current and/or changing needs.

For the most part, residents communicated that they liked their home and that they were happy with the staff who supported them. Many residents spoke about having lived in their homes for a long-time. Although the registered provider identified that engagement had taken place with one resident regarding the management of their finances and access to male staff, the resident told inspectors that they would still like to have more engagement with management regarding both matters.

A number of residents in the centre did not communicate verbally. Inspectors observed residents' physical prompts and body language which indicated they were content at the time the inspectors met with them. Inspectors also spoke with a resident's family member, who was very happy with the service their family member received in their home. Another elderly resident was observed to be very well responded to by caring and supportive staff who clearly knew the resident very well albeit in a very busy and cluttered environment.

Overall while residents were found to be cared for and kept safe, a collective campus based culture was evident in this service. The services de-congregation plan needed to be revised at registered provider level to ensure a more person centred and rights based approach to care provision was being driven. This plan had ceased due to COVID-19, and to be fair, the provider had been seriously challenged over the pandemic and was primarily focused on keeping people safe. The provider needed to ensure that all residents (who remained on this campus) were provided care in more suitable living environments aligned to their individual support needs.

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. Initial plans to move residents from this congregated setting to new homes in the community will be discussed under the capacity and capability section of this report.

Capacity and capability

This designated centre was registered for 29 residents. At the time of the inspection, 26 residents lived in the centre. The registered provider outlined at preliminary feedback that based on inspection findings no new admissions to the centre would take place and an application to reduce the centres capacity would be submitted to the Chief Inspector of Social Services following the inspection.

Overall this inspection found a very committed and cohesive management team were in place who were operating a safe service.

Senior management discussed plans to recommence transitioning the residents living in this campus into community houses. De-congregation had already begun, with a number of residents having transitioned to the community since 2014. Plans to move the remaining residents had been delayed as a result of the COVID-19 pandemic. As part of the registered provider's de-congregation plan, the registered provider had identified the resources that would be needed to de-congregate. However, the registered provider reported that they did not yet currently have access to the required funding/accommodation resources to move residents to new

homes within the community.

It was also noted that a number of residents who had already moved to homes in the community, had transitioned back into the campus setting. The rationale for these transitions was residents' changing needs, including the need for increased levels of support and supervision, which could not be provided in their community homes. While this practice was outlined in the organisation's policy on admissions, discharges and transitions it was not in line with the overall national commitment to de-congregate. It was evident that full de-congregation of this designated centre could not take place if the designated centre was still accepting internal transitions and return admissions. One resident who had recently transitioned back from their home in the community to this designated centre was documented to be upset and tearful when they were moved back to the campus. This transition was unplanned, due to changing needs following a medical event. Their friends that they lived with in the community visited them regularly in their home in the campus setting. When examined further, inspectors found this approach was largely directed by resources as opposed to resident rights. For example, the resident was being moved to where the staff were, as opposed to the staff being moved to where the resident lived.

Overall this inspection found that governance in this centre was stable and had kept residents safe throughout a very challenging COVID-19 pandemic period. Improvements where required however to ensure a more individualised and rights based approach was evident across all aspects of strategic planning and operational service provision to residents.

Regulation 15: Staffing

There was an adequate level of staff working with residents in this designated centre. It was evident that staff members were familiar with residents' needs, with many staff having worked in the centre for a number of years. This knowledge of residents' needs was invaluable, and ensured that consistent staffing was provided to them in their homes. However staff provision was very much in line with meeting basic needs such as support with eating/drinking, personal care and living within the centre. Further review was required to ensure appropriate individualised staff provision was meeting residents social activation and stimulation needs.

Staff spoken with told inspectors that activation of residents needed to be improved. This deficit was observed directly by inspectors also albeit relief/agency staff were being used to fill gaps on the roster. At the time of the inspection, there were approximately four staffing vacancies that the registered provider was trying to recruit. These staffing vacancies were required to ensure there was an improvement of activation of residents, and to provide them with more stimulation and activities in line with their interests.

17 staff personnel files were reviewed by inspectors and contained all of the required information outlined in Schedule 2 of the regulations including garda

vetting, references and qualifications.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A staff training matrix was provided to inspectors which evidenced that staff members completed mandatory training in line with the regulations. Staff were trained in areas such as Fire Safety, Safe Moving and Handling and Safeguarding.

Staff members were completing training in cardio-pulmonary resuscitation (CPR) at the time the inspection took place.

Performance management of staff members was carried out annually by the person in charge.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not have sufficient resources to action their plans to transition residents who continued to live in this congregated setting to new homes in their local community. It was also evident that the practice of moving residents back to this designated centre due to their changing support requirements was not appropriate, and that it contradicted the centre's de-congregation plans.

This designated centre had a competent and professional person in charge who was suitably qualified, with a wealth of experience and knowledge having worked with residents for a number of years. However, they were also responsible for the oversight of four other designated centres in their role as person participating in management. Furthermore this inspection found that the person in charge had a number of other additional organisational and clinical functions also (in addition to their role as person in charge). This remit was found to be far too large to ensure effective clinical oversight, management, monitoring and supervision of this large designated centre in its current form (five very busy 'units'), and to fulfil regulatory requirements.

Review by the registered provider is therefore required regarding the resourcing and governance remit of this centre in it's current form.

Judgment: Not compliant

Quality and safety

It was evident that residents were safe and cared for in their homes. However, improvements were required to improve the quality of life of residents, and to ensure that all aspects of their health care needs were appropriately met.

Risk management and oversight systems were found to be of a good standard. Learning from accidents and incidents were completed, and trends were identified to ensure appropriate control measures were put in place. This ensured the effective management of risk in the centre, in line with organisational policy.

Safeguarding and protection practices were reviewed and also found to be appropriate and responsive with residents found to be safe and protected in this centre.

Fire safety arrangements reviewed indicated safe and suitable practices regarding fire safety arrangements with containment, emergency lighting, equipment and evacuation procedures all found in place.

Residents healthcare was reviewed and a number of positive findings were made regarding clinical oversight, resident weights checks/reviews, clinical appointment attendance and the management and support of COVID-19. However improvements were also required in this area.

For example, dental input for one resident was not provided for a period of two years despite them having an assessed need regarding their oral health. This gap in dental treatment coincided with a lack of dental supports available to residents, as a result of the COVID-19 pandemic. At the time the inspection took place, the resident was recovering from significant dental surgery, having recently presented with indicators of pain. On review, it was noted that the resident had extensive nerve damage and required the removal of four teeth. The resident's oral health care plan had not been updated to outline the supports that they required to meet their oral hygiene needs post surgery. Another resident's oral health care plan clearly noted the deterioration in the resident's oral health over a period of one year. This was documented by the dentist as being caused by inappropriate dental home care, which the resident required full staff support to achieve in line with their assessed needs. This did not ensure that appropriate healthcare was provided to residents in their home.

Throughout the two days that this inspection took place, inspectors observed a number of practices which impacted on the rights of residents, their privacy and dignity. This included a number of practices which were institutional in nature, meaning that they focused of the collective and basic needs of residents, rather than a person-centred model of care. A number of practices also impacted on residents' ability to have meaningful choice and control over decisions relating to their care and support, and their daily life. Overall, the protection of residents' rights required thorough review on a number of levels to improve residents' overall quality of life

and to provide a more person-centred approach to care and support.

Regulation 17: Premises

The designated centre comprised of five units which were located in close proximity to each other in a congregated setting. Although some areas of the centre had been decorated to make them more homely, the overall environment was quite basic and clinical in nature.

Buildings were very large and expansive and were not kept in a good state of repair throughout. Some were old long ward based corridors with breeze blocked walls. Residents bedrooms were basic and consisted of single hospital beds or timber framed beds.

There was evidence of mould and exposed dampness in some areas, with cracked plaster and areas in need of painting and/or repair.

Due to the large size of these units and current staffing arrangements the maintenance and cleaning requirements of buildings of such a size needs was found to be substantial and needed to be reviewed.

A sluice room in one unit and utility room in another unit were observed to be visibly dirty on inspection.

The layout of the centre consisted of large buildings, many with vacant rooms filled with unused furniture and/or equipment. There was also equipment and clutter observed in communal areas and bathrooms. A number of residents' bedrooms were very small and their wardrobes and belongings had to be stored in other rooms in the centre. Areas of the centre were observed to require cleaning with dust and cobwebs observed.

One 'unit' had a high volume of residents and staff members, which meant there was little space for residents to relax, receive visitors and retreat and seek privacy if they so wished. Some residents had hearing impairments but did not use hearing aids so staff shouted continuously which had an obvious impact on the other residents living there who didn't have hearing impairments. The kitchen and dining area in this 'unit' was observed to be too small for the number of occupants and was very cramped and noisy at meal times, which did not provide for a relaxed and homely mealtime experience for residents. Whilst staff were observed to be doing their best, the care was observed to be provided in a functional and institutional manner as opposed to an individual rights based approach to care.

Inspectors observed that overall the premises were not laid out to meet the number and assessed needs of residents. These buildings were from the 1940's, 80's, 90's and early 2000's. Whilst some were found to be in better condition than others, none were observed to be homely environments.

Two residents shared a bedroom. This was observed to be an arrangement based on resource convenience as opposed to an arrangement based on choice or assessment of need. A privacy screen was used to provide some protection of residents' privacy however the bedroom was also cluttered and full of equipment. There was no plan in place to discontinue the use of this shared room, despite the fact that there were vacancies in the designated centre. Another residents bedroom had two beds in it whereby it had previously been occupied/shared but the bed was never removed. Environmental overhead hoisting was also required for some residents with increasing mobility support needs in bedrooms and bathrooms.

Judgment: Not compliant

Regulation 26: Risk management procedures

Residents' safety was maintained and protected at all times. When accidents or incidents occurred, these were documented and a review to identify any learning and improvements was taking place. Accident and incident reports were overseen by the health and safety officer and the registered provider representative. Trends were monitored with respect to accidents and incidents in the designated centre to prevent re-occurrence.

A low tolerance risk culture was observed in this centre with attention to detail and management meeting minutes demonstrating oversight for all risk issues identified.

A competent Health & Safety manager was in place who had good levels of risk oversight.

Inspectors reviewed the centres risk register, which identified the controls in place to reduce/minimise risks. A risk management policy was available and reviewed. This policy contained the information required by the regulations.

Overall risks were found to be well managed and residents were found to be safe.

Judgment: Compliant

Regulation 27: Protection against infection

This designated centre had experienced a number of outbreaks of COVID-19 infection. It was evident through discussions with staff and management that these outbreaks had been managed very effectively, in line with Public Health guidance. Staff and management were aware of the current advice on the management of suspected and confirmed cases of COVID-19. Staff members were observed wearing appropriate levels of personal protective equipment (PPE) throughout the inspection. Contingency planning was in place. The centre was found to have managed the

COVID-19 pandemic very well in very challenging circumstances.

Premises issues identified on this inspection are referenced under Regulation 17: Premises.

Judgment: Compliant

Regulation 28: Fire precautions

Fire-resistant doors were provided in the designated centre to provide effective containment in the event of a fire. Emergency lighting had been recently upgraded, following recommendations from an external fire safety competent person with expertise in fire safety systems. Fire-fighting equipment was also provided throughout the centre. Servicing of equipment was taking place and documentation was signed off.

Fire drills were carried out on a regular basis. It was evidenced that residents could safely evacuate the centre in the event of an emergency. There was a good fire safety and health and safety culture in this centre. The health and safety manager activated a fire alarm in one unit on this inspection which demonstrated fire doors closed and evacuation doors opened.

There was good oversight found to be in place to protect residents from the risk of fire.

Judgment: Compliant

Regulation 6: Health care

Improvements were found to be required in the area of healthcare provision and review in this centre.

One resident was recovering from dental surgery at the time of this inspection. On review of the resident's medical records and care plans, it was identified that they had significant plaque build up in a dental report in 2018. The resident had a dental review in 2019, however they did not receive a dental review in 2020 or 2021. This gap in dental treatment coincided with the COVID-19 pandemic, which impacted on the provision of dental services available to residents. The resident later presented with signs and symptoms of a dental issue. Upon dental review before the inspection had taken place, the resident required oral surgery where it was identified they required a number of teeth removed and had significant nerve exposure which would cause pain. Following this procedure, the resident's oral health care plan had not been updated to reflect that they had oral surgery, nor to outline updated recommendations on how to meet the resident's oral health needs as they recovered

from surgery. This did not ensure that appropriate healthcare was provided to residents in line with their assessed needs.

The inspector reviewed another resident's oral health care plan and records of dental review. It was noted by the dentist that there had been a deterioration in the resident's oral hygiene between the review in March 2021 and February 2022. This resident's oral hygiene was documented as being 'extremely poor', and noted that this was due to supports provided in their home in relation to oral hygiene as 'inadequate'.

An epilepsy support plan was in place for a resident. The plan identified that in the event of a seizure lasting three minutes, they would require administration of emergency medicine. However, in the resident's medicines administration record it was documented that this medicine should be administered after one minute. This conflicting guidance required review as it did not provide assurance that the correct course of action would be followed.

Judgment: Not compliant

Regulation 8: Protection

Safeguarding arrangements were in place and were found to be keeping residents safe and protected. Policies and procedures were reviewed and implemented. A designated officer role was currently being managed by the CEO with plans to reallocate this position. Allegations/disclosures of suspected/confirmed abuse in the organisation were being appropriately identified, reported and recorded. Links were in place with the local HSE Safeguarding Team. Inspectors reviewed a sample of reports of such safeguarding notifications, which had been made in line with statutory requirements. All safeguarding matters reviewed were found to be in order with resident safeguarding the paramount consideration.

Staff spoken with were aware of the pathways to highlight any concerns including alerting senior management, including the person in charge and the designated officer. A safeguarding policy was available to staff working in the designated centre who were also all provided with appropriate safeguarding training.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors observed a number of institutional practices which impacted negatively on the rights of residents, their privacy and dignity, levels of meaningful choice and control over decisions relating to their care and support, their quality of life and

levels of activation and stimulation in this centre.

Examples of these practices included;

- Two residents in one unit shared a bedroom. This practice was based on resourcing allocation as opposed to assessment of need or choice. This arrangement clearly impacted on both residents' right to privacy.
- A number of residents who had transitioned successfully to community homes had been moved back into this congregated setting. The rationale for these transitions was attributed to residents' increasing support needs which could not be met in their community homes. A resident was documented to be upset and tearful in leaving their community home to return to life in a congregated setting. This practice did not ensure that residents had choice and control over where they lived.
- It was observed that in one unit, there was little communal space for residents to relax and retreat due to the high number of residents living there and the high levels of staff members and students providing support to residents. Residents had no suitable location to receive visitors in private in their home.
- Inspectors observed staff members walking into residents' homes unannounced. Upon review, it was noted that a number of door bells were not working correctly, to alert staff and residents that someone was entering their home. Due to the layout of this campus-style setting, it was difficult to determine which entrance was the main entrance to each of the residents' homes. Therefore, staff and visitors often entered through back doors and side doors in the residents' homes.
- A number of residents were observed to have very low levels of activation when observing their care, reviewing their daily notes and their recorded goals/objectives outlined in their care plans. Residents were observed spending a lot of their time predominantly focused on their basic care and support needs. Residents were observed across the campus mainly in front of televisions for long periods on this two day inspection despite the fact it was warm and sunny on the days this inspection took place. Goals/Objectives in resident plans reviewed were of a very basic standard whereby some residents annual goals were 'to go for a drive or a walk'. The standard and quality of social goal setting and quality of life enhancement/activation required review.
- Residents' meal provision was managed centrally with meals being prepared in a communal kitchen and delivered on-site across the campus on trolleys/boxes to each of the residents' homes. Whilst kitchen staff spoken with and observed were very good and were resident focused, this practice restricted residents' choice with respect to menu choices, and an ability to engage in the purchase and preparation of food in their homes. Hence residents never experienced shopping, cooking and food preparation in their own homes or the smell of a home cooked meal.
- Residents' laundry was managed centrally through a central laundry.
- Residents' finances were managed centrally. Therefore residents did not have direct access to their finances unless this was requested in advance from the financial department. This system was under review at the time of inspection.

A review of local arrangements found residents finances were not accessible within the units. A resident told the inspector they wanted more access to their own money.

- Staff were observed using large medicines trolleys when administering residents' medicines. This trolley contained all residents' medicines, emergency medical equipment and equipment for monitoring residents' health including blood pressure monitors. This practice involved staff members bringing all of this equipment to a communal area for medicines administration. This occurred on occasions when this medical equipment was not required, and only a small amount of medicines required administration. This practice compromised residents' privacy and dignity, and promoted a clinical environment rather than a homely environment.

Overall inspectors found that staff in this centre were working very hard to keep residents safe. However further work is required to move towards a more rights based model of care provision.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Carriglea Residential Service OSV-0003509

Inspection ID: MON-0033238

Date of inspection: 18/05/2022 and 19/05/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Action 1:1 A provider review of activation staffing within the Designated Centre will be undertaken to establish the adequacy of supports and this to be completed by 31st July 2022. Action 1:2 By 31st December 2022 incrementally a team of 4 members of activation staff will be put in place and this is in line with pre-COVID 19 pandemic levels. Currently one activation member in place and one other member of staff deployed on a part time interim basis to support activation levels including social outing to town. The objective of the team is to ensure adequate staff members are in place to meet residents individualised social activation and stimulation needs. Re-assignment / Recruitment for the posts to commence immediately. Action 1:3 By 31st December2022 and earlier the Provider & PIC will for each of the 26 residents across the five residential homes liaise with respective keyworkers and request a review of goals and activation timetables within each residents person centred plan and consult with residents and their circle of support for the purposes of developing further meaningful individualised goals relevant to the resident and separate to basic levels of care. GOALS that were in place pre-pandemic are to be reviewed. External concerts have always been a favourite pre pandemic. This review of goals will guide the members of staff within the house and the activation team in the provision of appopriate social activation and stimulation. Action 1:4 Goals will include trips within the local community with friends and to restruants for meals out, teas /coffees', accessing the local greenway, meeting with famlies, holidays supported by the services or with famlies, hairdressing appointments in the community, increased engagement with famlies and attending evening concerts. 1:5 Carriglea Cairde Services is cognisant that 21 residents mobility is enabled by the use of wheelchairs and there is easy access for people to the main hall on Campus which will facilitate residents activation. Following the post Covid 19 Pandemic re-introduction of communal activities will allow people an opportunity to meet friends and share in activities including cooking, fun drums, return to church services, pet therapy, drama and the christmas and other shows. These activities will be undertaken in an environment	

that meets best practice in the context of infection prevention and control while ensuring residents rights are up-held.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A three year plan in relation to Governance and Management of Designated Centre will developed and will draw on the previous (pre-covid 19) 2018 and 2019 submissions. The key areas to be addressed are as follows:

Carriglea Cairde Services Plan is to provide people with homes in the community that appropriately meet people's needs. In the interim and immediately to ensure people's rights are respected, that people have positive experiences for many of their daily activities interim measures will be put in place while people continue to live on campus.

In summary the plan provides for 8 people to relocate from Campus to the Community in 2023. This will allow for the 18 people who continue to reside in Campus to live in 4 homes following the closure of St,Bridget's, - St Annes 6 residents, Oaklands 4 residents, Beechview 4 residents, Shalom 4 Residents. In the interim until de-congregation is achieved and community living is established for these residents the measures provided for will ensure adequate living and communal space is available for people to have positive daily life experiences.
Detailed Plan
Action 2.1: Meeting with HSE on 23rd June 2022 to provide a broad outline of the plan and to indicate that a resourcing business case submission will lodged by 31st July 2022.
Action 2.2: The Capacity of the Designated Centre will be reduced from the current capacity of 29 residents to 26 residents – 31st July 2022.
Action 2.3: Currently 24 residents have a single bedroom and by 31st January 2023 the remaining 2 residents in St. Anne's will each have a single bedroom.
Action 2.4: No new admissions from the waiting list for residential services to Carriglea Residential Service. Already In Place and now re-affirmed in this submission.
Action 2.5: No further transfer of residents from Carriglea Cairde Services other Designated Centres - lower support community houses owing to residents changing needs.- 24th June 2022.
Action 2.6 Restructuring Carriglea Residential Services resulting in the creation of 2 Designated Centres.
Action 2.7 By 31st December 2022 the formation of two Designated Centres from the existing Carriglea Residential Service and appointment of two Persons In Charge to the Designated Centre.
Action 2.8 By 31st January 2023 the number of residents in St. Anne's residential setting to permanently reduce by 1 thereby ensuring that all residents have single bed-rooms. In the interim until de-congregation is achieved and following the reduction in capacity daily

living experiences for residents including dining will be positive experiences for residents.
Action 2.9 4 residents to transition to a Community House in 2023. This house will be established as a new designated centre. In discussions with the HSE a suitable house in the community has been identified.
Action 2.10 A further purpose built community house to be developed in 2023 which will allow 4 other residents to transfer to the community in 2023. Discussion with Waterford City & County Council are on-going in relation to funding.
Action 2.11 Following implementation of 2.9 St Bridget's Residential Setting to close in 2023.
Action 2.12 The most person-centered transition of residents to be provided for – in as far as possible residents from existing locations to transfer in their current group to respective new settings rather than resident relocations being dispersed to a number of locations.
Action 2.13 Further business case by 31/07/2022 to Waterford City and County Council in regard to funding and development of two new residential settings.
Action 2.14 In 2024 two further houses to be sourced and provide for a further 8 residents to transfer to community based residential services.
Action 2.15 By 30th June 2023 remaining 10 residents not planned for by 31st July 2022 to have a long term residential plan based in the community which is to include the provision of housing in the community thereby ensuring full de-congregation of the campus.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider will work towards the deongregation plan outlined earlier– 8 Residents will relocate to Community Housing 2023 (two houses now identified – HSE & Waterford City & County Council in Support of Same) & 8 Residents 2024 (two houses to be identified and business case in relation to funding to be developed by 31st July 2022).
In the interim and until the decongreation plans have been developed the following actions will be implemented in regard to premises
Action 3.1 By 31st August 2022 a Provider Review of the décor of the five houses will be undertaken for the purpose of making homes more homely and the state of repair throughout will be reviewed and any proposed changes / improverments will be implemented and will include consultation with residents by 31st March 2023.
Action 3.2 By 31st July 2022 As identified within the report a review of residents beds and the use of hospital beds or timber framed beds will be considered and dis-continued as appropriate following the person centred review in consulation with residents and occupational therapy and new beds will put in place by the 30th September 2022.
Action 3.3 Commencing in July 2022 and ending on 30th September 2022 areas with mould and exposed dampness in some areas and cracked plaster and areas in need of painting and/or repair as identified within the report will repaired, painted , plastered and treated.
Action 3.4 By 31st August 2022 a review of the maintenance and cleaning requirements

of buildings across the desiganted centre and action plan on same to be developed. As per the report The sluice room in one residential home and the utility room in another residential home were observed to be visibly dirty on inspection such areas will be rectified by 30th June 2022.
Action 3.5 Across the designated centre unused furniture and/or equipment will be removed by 31st July 2022 and a review of the equipment and clutter in communal areas will be undertaken for the purposes of reducing and eliminating same and its impact for residents.
Action 3.6 By 31st July 2022 the provider will review the communal areas of St. Anne's residential which identified as being too small and develop a plan to reduce the impact of noise and the area being cramped at meal times. The interim plan will include staggered times mealtimes, re-design of space and establishing best ways to support residents with hearing difficulties that resuce impact on other residents. The residents of St Anne's will be reduced to 7 by 31st Jnauary 2022. The interim plan will provide on measures to improve the daily living experience of residents. Members of staff and residents will be consulted in relation to interim plans on how best to improve daily experiences for people who reside in St. Annes residential setting.
Action 3.7 In regard to the residential home where as set out in the report had a high volume of residents and staff members, which meant there was little space for residents to relax, receive visitors and retreat and seek privacy if they so wished. The number of residents will by 31st March 2023 reduce by 1 from the current 8 to 7 residents therby ensuring all residents have own bedroom and by the 01st September 2023 a reduction of 1 further resident from 7 to 6 residents will occur.
The objective of the Provider Review and findings is to create and provide for a relaxed and homely mealtime experience for residents.
Action 3.8 St Bridgets Residential setting will be closed in 2023 which will eliminate the old long ward based corridors with breeze blocked walls.
Summary:
2023 - 8 Residents to relocate off Campus 2023, St. Bridgets Residential Service to close and St Anne's Capacity to be set at 6, Shalom 4 Oaklands 4, Beechview 4. By the end of 2023 all residents to have own medium to large bedroom and communal facilities to include kitchen dining area and separate family / activities room thereby allowing for positive daily experiences.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
In June 2022, the outcome of the discussions between the PIC with the Public Dental Service is that Annual Dental Reviews are not yet being scheduled for residents and that an emergency service is only available / provided.

Action 4.1 A Provider Review of the appointment scheduling of the annual review of the oral health care for all 26 residents will be completed by 31st July 2022. The review will focus on the re-establishment of the person centred dental annual reviews for each

resident and to be undertaken by the Public Health Dental Service. In the interim where appointment other than emergencies are not available from the Public Dental Service private dental services will be sourced to undertake annual reviews and dental treatments.

Acrtion 4.2 Dental reviews will be held for each of the 26 residents by 31st December 2022 and thereafter annually.

Action 4.3 A review of the epilepsy support plans and prescription kardex is to be undertaken by the Person In Charge by 31st August 2022.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Action 5.1 by the 31st December 2022 the Provider is to establish a Rights Committee with membership of the Committee to Include Resident Repersentation.
Action 5.2 by the 31st December the Provider will undertake a review on instutional type practises within the Congregated Settings and will include recommendation and implementation plan.
Action 5.3 by 31st December 2022 the Provider will put place measures to support members of staff on residents rights, access to the community services and de-congreagation
Action 5.4 the two residents who currently share a bedroom will each have a bedroom by 31st March 2023.
Action 5.5 Immediately residents will no longer transfer back to the congregated setting. (24th June 2022).
Action 5.6 by 31st July 2022 the provider will have reviewed the communal areas of the residential setting identified as being too small and develop a plan to reduce the impact of noise and the area being cramped at meal times. The plan will aim to reduce excess furniture and increase circulation areas within the residential home. The number of residents will by 31st March 2023 reduce by 1 from the current 8 to 7 residents. The plan will address the rights for residents to receive visitors in private in their home.
Action 5.7 an awareness programme will be put in place to emphaise residents rights including members of staff to respect residents homes and not to walk into homes unannounced.
Action 5.8 by 31st July 2022 the Provider will undertake a review of door bells and entrances and exits to residential homes and issue protocol across the Designated Centre on same for members of staff and visitors.
Action 5.9 By 31/12/2022 for residents whom the report identified to have very low levels of activation - A team of 4 members of activation staff will be put in place and this is in line with pre-COVID 19 pandemic levels. The objective of the team will be to ensure adequate staff members are in place to meet residents individualised social activation and stimulation needs. Recruitment/ Reassignment for the posts to commence immediately. For each of the 26 residents across the five residential homes, respective

keyworkers will undertake a review of goals and activation timetables within each residents person centred plan and consult with residents and their circle of support for the purposes of developing further meaningful individualised goals relevant to the resident and separate to basic levels of care. This review of goals will guide the members of staff within the house and the activation team in the provision of appopriate social activation and stimulation. Carriglea Cairde Services is cognisant that 21 residents mobility is enabled by the use of wheelchairs and there is easy access for people to the main hall which will facilitate residents in the participation following the post Covid 19 Pandemic re-introduction of communal activities and this will allow people an opportunity to meet friends and share in activities including cooking, fun drums, return to church services, pet therapy, drama and the christmas show. These activities will be undertaken in an environment that meets best practise in the context of infection control and guidelines in relation to the 4th Covid 19 vaccine – (18 residents over 65.).
Action 5.10 By 31/12/2022 in regard to residents meal provision the Provider will undertake a review of current levels of meals prepared in the home and those brought to home from the central kitchen and prepare findings and recommendation towards further meal preparation and cooking in home in a person centred and inclusive basis. The review will include individualised diets.
Action 5.11 By 31/12/ 2022 through the activation team residents will be supported to engage increased levels of choice with respect to menu choices, and engagment in the purchase and preparation of food in their homes.
Action 5.12 By 31st December 2022 in regard to residents' laundry each home is currently equipped with its own washing machine and dryer and a small amount of laundry is completed in each home daily and the daily reliance on the larger volumes of clothes and bed linen transferred to the central laundry will be reviewed.
Action 5.13 By 31st December 2022 the Provider will review and recommend on the systems to have in place greater access for residents' to their finances and less reliance on the centralised management. This will include purrhase cards greater use of technology.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2022
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	Orange	31/03/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/03/2023

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/09/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2023
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	31/01/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2024
Regulation 06(1)	The registered provider shall provide appropriate health care for each	Not Compliant	Orange	31/12/2022

	resident, having regard to that resident's personal plan.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/12/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/12/2022