Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	The Haven
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	07 March 2022
Centre ID:	OSV-0005236
Fieldwork ID:	MON-0033629

About the designated centre

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

The Haven is located in a rural area of County Kildare and provides 24-hour residential supports to five adults with an intellectual disability. The centre consists of a large two-storey house with an adjacent self-contained single apartment. In the main house the ground floor consists of a kitchen, utility area, living room, sitting room and bathroom and four bedrooms, one of which is the staff sleepover room/office, with another two bedrooms and a bathroom upstairs. There is also a staff office and games room/staff sleepover room. The apartment contains a kitchen-dining room, a sitting room, a sensory room, bedroom and large bathroom. There is also a spacious garden for recreational use and spacious grounds surrounding the house and apartment. The staff team is made up of social care workers, assistant social care workers, deputy managers, and a person in charge. Nursing input is available from a nurse employed in the wider organisation.

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
Monday 7 March 2022	09:55hrs to 16:15hrs	Gearoid Harrahill	Lead
Monday 7 March 2022	09:55hrs to 16:15hrs	Thomas Hogan	Support

What residents told us and what inspectors observed

During this unannounced inspection, the inspectors had the opportunity to briefly meet residents and members of support staff, and had an opportunity to observe some of the day structures of residents in the centre and review topics discussed in house meetings.

Three residents were supported in a large two-storey countryside house, with one resident supported in a separate single-occupancy apartment on the same premises. The main house was featured with a spacious and bright kitchen and dining room area, and three sitting rooms in which residents could spend time alone or with their support staff. The apartment had its own facilities such as a kitchen, dining room, TV lounge and wetroom. Each resident had a private bedroom which offered suitable space and sufficient storage for personal belongings. Bedrooms seen by inspectors were found to be highly personalised and decorated based on residents' hobbies and interests. Multiple service vehicles were available to optimise each person's access to the community and preferred activities, including shopping trips, day services and gardening therapy at a nearby allotment.

As inspectors were shown around the service, a number of areas were observed in need of repair and maintenance which impacted upon the homely appearance of the premises. Inspectors observed cracks and holes in the walls and ceilings of some areas of the house, and rooms in need of repainting. Some of the walls were stained or spotted around the house. Substantial attention was required in the cleanliness and maintenance of some of the bathroom facilities, which included a leaking toilet, unclean walls and tiles, broken taps, rusted light fixtures above bathroom mirrors, and a build-up of mould in the shower areas. There was also a malodour of stagnant water in or near the bathroom areas, and staff noted that there had recently been a pipe leak in the centre. Also impacting negatively on the appearance of the residents' home was damaged plasterwork and moss on the external walls, paving and balcony. The vehicles were also quite dirty internally and externally, and improvement was required on how cleaning equipment and products were stored when not in use.

Inspectors observed patient and friendly interactions between staff and residents, and staff who spoke with inspectors were familiar with residents' support needs. Examples were observed of staff supporting a resident who was distressed and upset during the day, discussing and observing what may be causing their discomfort and how best to support them until they felt better. Some residents wished to spend time alone in their living room or to stay in bed late, and this was respected.

Residents attended house meetings on a regular basis. Inspectors reviewed a sample of the minutes of these meetings and found them to discuss topics which were meaningful to them. Residents were reminded of the expectations with shared living spaces and having mutual respect for their housemates, and encouraged to

speak to staff if they ever felt upset or annoyed in their home. Staff and residents discussed healthy eating goals and balanced diets, and planned treats such as takeaways for the weekend. Household chores were also divided in these meetings, including vacuuming, loading and unloading the dishwasher, doing personal laundry, and emptying the bins. The meetings were also used to discuss news such as the change in centre management and updates related to the social restrictions of the COVID-19 pandemic.

The next two sections of the report 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 delivered.

Capacity and capability

Inspectors found that overall, the provider had appropriate governance structures in place to manage the designated centre at a local and provider level. Systems were in place for ensuring that the service delivered appropriate level of support to residents and that the provider maintained oversight of areas in need of development. However some improvement was required in ensuring that objectives related to quality improvement were effectively identified and progressed in a timely fashion.

There had been a recent change in management for this designated centre, with a new person in charge coming into the role in January 2022. The person in charge evidenced a good level of knowledge of the residents' needs, histories, interests and personalities, as well as the staff team and ongoing risks in the designated centre. They also had scheduled time over the coming weeks to conduct formal supervision and performance management sessions with each member of the team. In discussions with inspectors, the person in charge had plans for how they intended to enhance the service, primarily in developing on the social and independence opportunities for the residents at home and in the community.

The service had a number of staff vacancies at the time of the inspection, with relief personnel assigned to the centre to enhance the staffing numbers until recruitment was completed. Inspectors reviewed a 28-day sample of staffing roster records, and found that for a number of shifts there was no name identifying who worked in the centre. As such, there was insufficient evidence to indicate if continuity of staff support was consistently maintained when relief personnel were used. It was also not consistently clear who led shifts on the days on which the person in charge and their deputies were absent at the same time.

The provider had clearly identified which training and skills were required to work in this designated centre based on the needs of the service users. Inspectors were provided the manager's system for identifying requirements for training attendance. Staff were up to date on the majority of mandatory training such as fire safety,

safeguarding of vulnerable adults, medication management, first aid, and supporting people with autism or Asperger's syndrome. There were some gaps in staff attending training sessions in positive behaviour support management and infection prevention and control. The records available for inspection did not include the status of staff training in some areas identified as required for this service, including supporting residents with communication needs, diabetes, epilepsy and mental health support. The records included relief personnel to facilitate the management to be assured that these staff members were provided the same training and refresher courses as the core team in the centre.

The provider had a policy and procedure for the receipt and management of complaints in the service. For a sample of recorded complaints there was a note on the actions taken to resolve the matter and the learning going forward.

Inspectors reviewed the service agreements in place for all four current residents, which were available in a simple language format. These agreements had not all been signed by the provider,or by the resident or their representative. There were also some parts of terms of the contracts in which the choice relevant for the resident had not been selected.

The provider had completed their annual report on the quality and safety of care in the service in July 2021. This reflected on the systems in place to ensure that residents were safe in the service, were supported in their healthcare needs, and had their privacy and right to voice their concerns in their home respected. The provider described systems in place to collect experiences and feedback from residents and their representatives, such as house meetings, surveys and keyworker sessions. However, the findings acquired from these measures, or any other commentary from residents and their representatives, did not feature in the annual report. The provider had also conducted an unannounced quality audit of the service in January 2022. This audit was quite detailed and specific in identifying areas in need of development or enhancement in the service, including a number of the areas identified by inspectors on this visit. Specific, time-bound objectives were set out to address the findings of these reports, and inspectors found that the completion or progress on these goals was mixed.

Regulation 14: Persons in charge

The person in charge was full-time in the role and holds the post for two designated centres. They had suitable management deputation arrangements in place for when they are absent from the centre. The person in charge provided evidence on how they had become familiar with the residents and staff team of this centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing rosters in the designated centre were not complete, with inspectors noting days for which there the staff member on shift was not identified, and as such it could not be determined from these records if the impact on support continuity was mitigated for days on which the service used relief personnel. It was also not consistently clear who led shifts.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were a number of gaps in mandatory training for staff members, and other required skills and training for which there was no record of their completion available for review.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The director of residents was available for review and contained the information required under the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider had conducted detailed audits of the service and had completed their annual and six-monthly reviews as per the regulations. Some of the actions to address the findings of these reviewed remained outstanding at the time of the inspection. Some of the oversight arrangements such as cleaning schedules had not been effective in identifying deficits in the premises hygiene. Development of the annual report was required to ensure that it is composed in consultation with the residents and their representatives and is reflective of their commentary and feedback.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Residents had a written contract with the provider but the terms were not consistently identified and the contracts were not signed between the resident, or their representative, and the service provider.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose in place for the centre, however the information in this document had not been revised to reflect current information.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Events and incidents requiring notification to the chief inspector had been done within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had responded to complaints raised in the designated centre and had notes on actions taken in response to complaints.

Judgment: Compliant

Quality and safety

The inspectors found that on the whole, there were suitable arrangements in effect to keep residents safe in their home. Improvements were required in the ongoing evaluation of the effectiveness of resident support plans and the guidance provided to support staff in responding to identified needs. Improvement was required in the

upkeep and cleanliness of the designated centre, as well as in the effectiveness of systems by which the service provider was assured that the environment was well-maintained and homely for the service users.

Inspectors reviewed a sample of residents' needs assessments and support plans. Needs assessments had been recently conducted and were comprehensive in nature, covering a wide range of support requirements. However, in some cases, it was not clear from the assessment what the identified needs of the resident were, and some assessed needs which had been identified did not have a corresponding support plan in place. For example, where an assessment had identified a need for a support plan for a resident to manage their finances, this had not been developed. In the case of an epilepsy management plan, it was not clear what signs and symptoms present for that person to provide sufficient guidance on supporting the resident. Inspectors found a lack of evidence to indicate that the effectiveness of support plans was being evaluated, and evidence that reviews were completed in a multidisciplinary manner.

Some residents had a positive behaviour support plan in place, which clearly defined the various behaviours with which residents may present. These plans described precursor behaviours, proactive and reactive strategies to be used by staff to maintain a low-stress environment, and the desired outcome of the behaviour support plan. Some plans identified residents who may present with a wide variety of verbal, physical or self-injurious behaviours. In these instances, the circumstances which may trigger an incident were described collectively rather than identifying the settings and triggers which may causes of each variation of their behaviour, based on analysis of incident history. As a result, some responses were not specific to each behaviour with which the resident may present. The guidance provided to staff indicated that physical intervention measures may be required, as last resort when other de-escalation strategies have not been successful. The description or range of the physical intervention prescribed for use was not described or illustrated in the plan, to provide assurance that staff response is consistent and proportional based on that resident's specific support needs.

A high level of physical and environmental restrictive practices were in use in this designated centre. There were plans in place to reduce or discontinue some of these practices where there had been a reduction in the associated risk to the residents or staff members. Restrictive practices review meetings took place, most recently in November 2021, however it was unclear from the record of these meetings how the continued use of some practices was being approved. The restrictive practice register included practices which had been recently used, rather than what was approved for use in the centre. Inspectors observed some examples of practices which were not identified as restrictive in this centre register, for example net dividers in cars and televisions being secured in acrylic containers.

Inspectors found systems in place in the designated centre for the assessment, management and ongoing review of risks and emergency response plans. Inspectors reviewed a sample of incident logs in the centre. These included the details of the event and action taken by staff in response. Where the incident constituted a potential or actual safeguarding risk, they were reported to the regional

safeguarding team for review. Inspectors reviewed examples of where the provider had taken actions or investigations to be assured that the residents were safe, and were happy to continue living in this centre with their peers. The centre had a policy and procedure on risk management which was last reviewed November 2020. Improvement was required to ensure this policy included information on all topics required under the regulations.

Staff were clear on procedures for identifying potential safeguarding incidents and were assured that they could raise concerns related to the safety and dignity of residents in the house. For residents who required support with managing money and debit cards, inspectors found that staff followed appropriate procedures for auditing transactions and bank activity to safeguard residents from financial exploitation.

Inspectors conducted a review of the premises of the designated centre, including the primary house, the stand-alone apartment, and the service vehicles. There were a number of areas which were not clean or in an acceptable state of maintenance on inspection. Inspector observations included, but were not limited to, the following examples:

- Resident bathrooms included a toilet leaking onto the floor, broken sink taps, rusted light fixtures, mould build-up on the ceiling, faecal matter stains on the fixtures and walls, and shower enclosures and wet-rooms which were dirty or had a build-up of mildew.
- Holes and cracks on walls, ceilings and skirting boards.
- Stains and dirt on windows, walls, floors and wall switches.
- Cracked surfaces and moss build-up on the external grounds, balcony and walls.
- One bedroom in need of repainting after damage caused by a leak in the adjacent bathroom.
- A malodour of stagnant water in a shared bathroom and in the stand-alone apartment of the designated centre.
- Vehicles with stains and food on the seats.
- Areas for storing cleaning equipment which contained leaves, dirt and garden debris which was also found the cleaning equipment for the house such as the mops, buckets, brooms and dustpans.

The cleaning checklist in place for these areas had been signed off as being cleaned through the week up to the evening before this inspection, or in the case of the vehicles, on their most recent use. In light of the findings of the premises review, the inspectors required the provider to take immediate action to address the areas listed above which are relative to the cleanliness of the designated centre. In the days following the inspection, the service provider provided written confirmation that a thorough cleaning of the centre had been done by staff after the inspection. The provider also confirmed that an external cleaning contractor had been scheduled to perform an additional deep-cleaning of the service, and that maintenance works had been scheduled.

The premises was equipped with appropriate fire safety infrastructure, including

self-closing doors, smoke seals, emergency lighting, and firefighting equipment, which was all tested and serviced on a routine basis. Staff spoke with inspectors regarding the routine propping open of one bedroom fire door for reasons related to the residents' support needs. Where doors are kept open due to preference or necessity, this must be done in a way that does not compromise the containment features of doors. This propping had not been identified to add a more appropriate method, with a routine checklist confirming that no doors were held open in the service. The provider had conducted a number of practice evacuation drills simulating scenarios including night-time staffing levels. Inspectors reviewed a ten-month sample of drill reports and found that there had been an overall reduction in the time taken to evacuate to a place of safety, from 10-15 minutes down to 4-7 minutes, however there was limited evidence on what action and learning was being taken to reduce times to an appropriate level for this type of setting.

Regulation 17: Premises

A number of areas of the designated centre were in a poor state of maintenance or cleanliness, which in turn impacted upon the pleasant appearance of the residents' home.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had a risk register in place which was comprehensive in nature and contained risks which were appropriately assessed and controlled with suitable risk ratings. There were some gaps in the contents of the risk management policy and procedure of the requirements under the regulations.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were a number of areas around the designated centre which were visibly dirty. Cleaning equipment such as mops and brooms, and the storage areas for same, were not clean on inspection. Some areas of surface damage compromised their ability to be effectively cleaned and sanitised. There was a cleaning checklist in place for staff, which was routinely completed but had not been effective in ensuring that the environments listed were clean. The service contingency plan for COVID-19 was limited in detail and did not provide guidance on steps to supplement staff in

the event that many centre personnel were absent at the same time.

Judgment: Not compliant

Regulation 28: Fire precautions

Overall, the centre was equipped to detect, identify and fight the spread of fire and smoke on the premises and provide suitable maps and lighting to aid evacuation. However, inspectors identified an upstairs fire door which was routinely held open in a manner which compromised the fire containment feature. The provider conducted routine practice evacuation drills, with some improvement required to identify how the learning from the drills would be used to achieve a safe and efficient evacuation time.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

In the sample reviewed, the comprehensive assessments of need did not clearly summarise and outline the identified support needs of residents. Support plans were in place for the majority of needs which the inspector could identify from the assessments, however, in some cases these provided limited information which is relevant to support staff on supporting the assessed needs. There was a lack of evidence of multidisciplinary review of support plans, or of the effectiveness of the support plans.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The positive behaviour support plans reviewed by inspectors did not provide appropriate guidance on the management of some behaviours. In particular, functional analysis, incident history and frequency, and the causes and trigger for each specific behaviour were not clearly defined.

The descriptions and definitions of physical restraint interventions were not included and it was not possible for staff to be fully informed of what intervention is acceptable and prescribed as effective for that person. This is of concern given that physical intervention was frequently used in 2021.

It was not clear what the procedures for approving or prescribing the continued use

of restrictive practices were in the designated centre. Some practices observed in the environment had not been considered as restrictive practices in the centre's register of same.

Judgment: Not compliant

Regulation 8: Protection

Inspectors were provided evidence to demonstrate that alleged or actual safeguarding incidents were investigated and referred to the relevant external bodies for their review. The provider had taken measures to be assured that residents felt safe and were comfortable with their living arrangements and peer group. Systems were in effect to monitor resident finances to safeguard against financial abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Examples were observed of residents' choices and preferred routines being respected by the staff team. Resident forum meetings were held regularly and were used to share news and updates, divide household jobs and remind residents of their rights and expectations in a shared living space.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Haven OSV-0005236

Inspection ID: MON-0033629

Date of inspection: 07/03/2022

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: 1. The Person in Charge (PIC) completed a review of 'actual' and 'planned' rosters in the centre, to ensure staffing levels are correct and in line with individuals assessed needs. This was completed on 23rd March 2022. The PIC will continue to review staffing levels daily. 2. In conjunction with the recruitment team, the Person in Charge (PIC) and Director of Operations (DOO) will review the Centre's recruitment plan on an ongoing basis. 3. The Centre's Staffing Contingency Plan will be reviewed and updated by the Person in Charge to clearly outline the Staffing Arrangements in place to meet the assessed needs of individuals as well as what measures are implemented to maintain continuity of care. 4. The Statement of Purpose was reviewed and updated by the Person in Charge to ensure staffing levels are aligned with the Centre's existing staffing levels and individual occupancy level, as well as referencing staffing levels at full occupancy. This was completed on 23rd March 2022 5. The PIC shall discuss the above points at the next monthly Staff Team Meeting held by 29th April 2022.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

1. The Person in Charge shall complete a full review of the training needs of all staff to ensure all staff members have received the appropriate training in line with the assessed needs of the individuals.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Person in Charge (PIC) shall complete a review of the Centre's annual review report and ensure the individuals and their representative's feedback is contained within.

2. The Person in Charge (PIC) shall conduct a review of the management systems in place regarding Infection Control Practices in the Designated Centre so as to ensure that.
a) All daily hygiene tasks and standard operating procedures in regards infection control are appropriate to the residents' needs.
b) Following the review, the PIC shall ensure that hygiene tasks and standard operating procedures regarding infection control are effectively monitored daily by the Designated Centre's management team.
c) Staff receive additional refresher training on the Designated Policy and Procedure [PL-C-031] on Infection, Prevention Control Practices by 29 April 2022

3. The PIC shall discuss the above points at the next monthly Staff Team Meeting held by 29th April 2022.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
1. The Person in Charge has completed a full review of individuals contracts for provision of services and ensured all contracts for provision of services have been signed by the individual, their representative, and PIC. This was completed on
16th March 2022.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
1. The Statement of Purpose was reviewed and updated by the Person in Charge to ensure staffing levels are aligned with the Centre's existing staffing levels and individual occupancy level, as well as referencing staffing levels at full occupancy. This was completed on 23rd March 2022

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The Person in Charge ensured a full deep clean of the Centre including the areas identified on the day of the inspection was completed on 8th March 2022 and written confirmation was provided by the PIC to the authority within 48 hours as requested. Additional cleaning was completed by external cleaning contractor on 10th March 2022.

2. The Person in Charge and Area Director of Operations completed a review with the maintenance department and a schedule was set for completion of required works identified in the inspection.

3. The Person in Charge (PIC) shall conduct a review of the systems in place regarding the management / overview of maintaining Premises in the Designated Centre so as to ensure that.
a) A review of the Centre and its layout and environment is checked daily, and any maintenance or repairs are scheduled and addressed.
b) Any maintenance or repairs required are scheduled and addressed in a timely manner.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. A full review of the Risk Management Policy shall be completed by the Area Director of Operations to ensure that it reflects the following.
a) arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents; and
b) arrangements to ensure that risk control measures are proportional to the risk

identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. The Person in Charge (PIC) shall conduct a review of the management systems in place regarding Infection Control Practices in the Designated Centre so as to ensure that.
a) All daily hygiene tasks and standard operating procedures in regards infection control are appropriate to the residents' needs.
b) Following the review, the PIC shall ensure that hygiene tasks and standard operating procedures regarding infection control are effectively monitored daily by the Designated Centre's management team.
c) Staff receive additional refresher training on the Designated Policy and Procedure [PL-C-031] on Infection, Prevention Control Practices by 29 April 2022

2. The PIC shall ensure that the Centre's management team complete an e-Learning Module 'National Standards for Infection prevention and control in community services: Putting the standards into practice'.

3. The Centre's Staffing Contingency Plan will be reviewed and updated by the Person in Charge to clearly outline the Staffing Arrangements in place to meet the assessed needs of individuals as well as what measures are implemented to maintain continuity of care.

4. The above points are to be discussed with the staff team at the next monthly team meeting by 29th April 2022

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The Person in Charge (PIC) will conduct a review of the Designated Centre's fire safety procedures to ensure that.
a) There is adequate means of escape which reflect the Individuals needs and evacuation methods likely to be employed.
b) Following the review, the PIC will ensure individuals relevant Care Plans and Personal Emergency Evacuation Plans (PEEPS) are updated to adequately accounted for the mobility and cognitive understanding of Individuals in the evacuation procedure.

c) The PIC will ensure all Individuals in the Designated Centre are fully informed of their updated PEEPS through key-working sessions with their Staff.

2. The PIC will complete a fire drill with minimum staffing levels to ensure all individuals can safely evacuate the Centre within an efficient evacuation time. If improvements are required, the PIC will ensure an action plan is completed with set timeframes for completion of same.

3. The above points are to be discussed with the staff team at the next monthly team meeting by 29th April 2022

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. The Person in Charge will complete a full review of all individuals' comprehensive needs assessments and reflect any updates in their Personal Plans in conjunction with the behavioural specialist.

2. The PIC shall discuss any changes to comprehensive needs assessments and Personal Plans with staff team at the next monthly staff team meeting held by 29th April 2022.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The Behavioural Specialist in conjunction with the Person in Charge will continue to review and update Multi-Element Behaviour Support Plans (MEBSP) and section 5 of individuals personal plans, as required. Updated plans will be communicated to the staff teams.

2. The PIC shall continue to review all incidents in the centre to ensure the MEBSP and proactive and reactive strategies are being followed and are effective in managing incidents of concern. Learnings identified from incidents will be communicated to all staff team through daily handover for a period of 7 days and discussed in detail at staff team meetings.

3. The PIC and Behavioural Specialist have completed a full review of all restrictive practices within the centre. This occurred on 23rd March 2022. Minutes of this meeting were completed and shared with the staff team.

4. The PIC shall discuss the above points at the next monthly staff team meeting held on or before 29th April 2022.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	29/04/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	29/04/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional	Substantially Compliant	Yellow	29/04/2022

	development programme.			
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	Orange	29/04/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Red	09/03/2022
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.	Substantially Compliant	Yellow	29/04/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	29/04/2022
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their	Substantially Compliant	Yellow	16/03/2022

	representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	29/04/2022
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	29/04/2022
Regulation 27	The registered provider shall ensure that	Not Compliant	Orange	29/04/2022

	residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	29/04/2022
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	29/04/2022
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	23/03/2022
Regulation	The person in	Substantially	Yellow	29/04/2022

05(1)(b)	charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Compliant		
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	29/04/2022
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	29/04/2022
Regulation 05(6)(c)	The person in charge shall ensure that the	Substantially Compliant	Yellow	29/04/2022

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	29/04/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	29/04/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is	Substantially Compliant	Yellow	29/04/2022

	made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	29/04/2022