Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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|---|---|
| Name of designated centre: | Glenageary |
| Name of provider: | St John of God Community Services Company Limited By Guarantee |
| Address of centre: | Co. Dublin |
| Type of inspection: | Announced |
| Date of inspection: | 18 July 2018 |
| Centre ID: | OSV-0003578 |
| Fieldwork ID: | MON-0021797 |

## About the designated centre

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

The designated centre is based in a suburban area of South County Dublin and is comprised of three community based units. One unit is a detached house and is home to five residents, the second is also a detached house and home to six residents while the third is a semi-detached property and is home to five residents. The centre provides 24 hour residential supports for residents availing of its services and places a focus on providing person centred care, promoting independence, enhancing community integration and participation, and enhancing the quality of life of residents.

**The following information outlines some additional data on this centre.**

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| Current registration end date: | 23/12/2018 |
| Number of residents on the date of inspection: | 11 |

## How we inspect

To prepare for this inspection the inspector or 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 |
|---|---|---|---|
| 18 July 2018 | 09:00hrs to 19:00hrs | Thomas Hogan | Lead |
| 18 July 2018 | 09:00hrs to 19:00hrs | Michelle McDonnell | Support |

## Views of people who use the service

The inspectors met and spoke with five of the 11 residents availing of the services of the designated centre. In addition, the inspectors spoke with two family members of residents at the time of inspection. Views of residents were found to be very positive with regards to the service they were in receipt of. Residents stated that they were satisfied with the care and support they received and felt safe living in the centre. Family members spoken with by the inspectors expressed similar views with examples of high quality care and support being outlined. In addition to speaking with residents and family members, the inspectors received 16 completed questionnaires. Strong themes of satisfaction with the services provided emerged from a review of the questionnaires completed, however, it was noted that themes emerging also included residents requesting further opportunities to engage in activities outside of the centre, and dissatisfaction with arrangements in place for the sharing of bedrooms in some cases.

## Capacity and capability

Nine regulations were inspected against relating to *capacity and capability* and overall, the inspectors found mixed levels of compliance across these regulations. Two regulations were found to be in full compliance while five were found to be substantially compliant and two were found to be not-compliant. Areas which required improvements included governance and management, staffing, and training and development.

The inspectors met with the person in charge who had recently been appointed to the centre. The person in charge demonstrated appropriate knowledge of the legislation and their responsibilities. In addition, the inspectors found that they held the necessary experience and qualifications to carry out the role. While the person in charge was employed in a full-time capacity, it was found that they were responsible for the management of two designated centres. The person in charge outlined how a campaign was underway to recruit a full-time supervisor to support them in the role for this centre.

A review of staffing arrangements in the centre found that in one unit the number of staff employed did not meet the needs of residents. In this case it was found that the number of staff employed did not allow for appropriate supports to be in place at all times. Staff members were observed by the inspectors to interact with residents in a kind and respectful manner throughout the period of the inspection. Staff members were observed to facilitate a supportive environment and advocate on behalf of residents. A sample of three staff files reviewed by the inspectors found that all required information as set out in the regulations was present. Actual and planned staff duty rosters were not satisfactorily maintained in the centre as required and duty rosters which were in place did not contain the name of the centre. A relief panel was used to supplement duty rosters and it was found that a

core number of relief staff were employed on a regular basis to ensure continuity for residents.

Staff training records were reviewed by the inspectors and it was found that six of seven mandatory training areas had not been completed by all members of the staff team. Nine per cent of staff had not completed training or refresher training in the areas of safeguarding vulnerable persons, safe administration of medication and manual handling; 27 per cent of staff had not completed training or refresher training in epilepsy management; 36 per cent of staff had not completed training or refresher training in diabetes management; and 53 per cent of staff had not completed training in food hygiene. A local plan was in place to address these identified training deficits. This action had been identified at the time of the last inspection but had not been resolved.

The inspectors found that there were satisfactory arrangements in place for the supervision of staff employed in the centre. Informal supervision took the form of the person in charge being present in every unit of the centre at least once weekly and the completion of regular team meetings. Formal supervision was in place with one-to-one meetings with all staff members. While there was an organisational policy requirement for these supervisions to take place at least on a quarterly basis, it was found that they were not completed with all staff in this time period. The inspectors found, however, that the person in charge had recently introduced a system for tracking and scheduling supervision meetings which planned to address this matter.

Governance and management arrangements in the centre were reviewed by the inspectors and it was found that while overall there were clear examples of effective governance, there were areas for improvement found relating to oversight and the self-identification of areas of risk and non-compliances with the regulations. An annual review and six monthly unannounced visits reports were found to be comprehensive in nature, however, failed to recognise the concerns identified by the inspectors relating to fires safety for example. An unannounced six monthly visit report dated July 2018 was found to state that fire safety was in 97 per cent compliance with the regulations, however, the inspectors found this to be an area of non-compliance with the regulations.

A review of admissions and discharges in the centre found that there had been none since the time of the last inspection. Through discussions held with the person in charge and registered provider, it was found that there was a clear and planned approach to admissions and discharges in the centre and residents availing of services would be informed of and consulted with regarding new admissions. While all residents were found to have written agreements in place for the provision of services, the inspectors found that six of the 16 contracts on file had not been signed by a resident or person(s) on their behalf.

A statement of purpose (dated May 2018) was reviewed by the inspectors at the time of inspection. It was found that several areas of the document did not comply with the regulatory requirements and feedback was provided to the person in charge and registered provider on this matter. An opportunity to revise and update

this document following this feedback was provided and a revised statement of purpose was submitted to the inspectors following the inspection. The revised statement of purpose (dated July 2018) was reviewed and found to contain three areas of non-compliance. These areas related to the full-time equivalents of the staff and management team of the centre not being clearly outlined, details of any specific therapeutic interventions and the arrangements made for their supervision not being satisfactorily outlined, and the emergency procedures in place in the centre not being included.

The inspectors reviewed the procedures in place for the management of complaints. It was found that there was a culture of awareness created in which residents were informed of how to make a complaint and empowered to do so if required. There were easy read complaints procedures on display in the centre along with pictures of complaints officers. The inspectors found, however, that some complaints which had been active since 2013 had not been fully resolved. In addition, the complaints register in use for logging all complaints was not satisfactorily maintained.

A review of written policies and procedures found that all required policies as outlined by Schedule 5 of the regulations were present in the centre. The inspectors found that three of the policies had not been reviewed and updated in at least three years as required. These policies were: the admissions, including transfers, discharges and temporary absences of residents policy; the provision of behavioural support policy; and the staff training and development policy.

## Regulation 14: Persons in charge

The person in charge demonstrated appropriate knowledge of the legislation and held both the experience and qualifications required by the regulations.

Judgment: Compliant

## Regulation 15: Staffing

The number of staff employed in one unit of the centre was found not to meet the needs of residents. Actual and planned staff duty rosters were not satisfactorily maintained in the centre as required and duty rosters which were in place did not contain the name of the centre.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

The inspectors found that six of seven mandatory training areas had not been completed by all members of the staff team. In addition, formal supervisions were found not to have been completed with all staff in line with organisational policy time frames.

Judgment: Not compliant

## Regulation 22: Insurance

There was a policy of insurance in place in the centre which insured against accidents or injury to residents.

Judgment: Compliant

## Regulation 24: Admissions and contract for the provision of services

While all residents were found to have written agreements in place for the provision of services, the inspectors found that six of the 16 contracts on file had not been signed by a resident or person(s) on their behalf.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

A revised statement of purpose was submitted to the inspector post inspection and this version was reviewed and found to contain three areas which were in non-compliance with the regulations.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

The inspectors found that some complaints which had been active since 2013 had not been fully resolved. In addition, the complaints register in use for logging all complaints was not satisfactorily maintained.

Judgment: Substantially compliant

## Regulation 4: Written policies and procedures

The inspectors found that three of the policies had not been reviewed and updated in at least three years as required.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Internal governance and oversight arrangements in place in the centre failed to identify areas of concern and non-compliance with the regulations.

Judgment: Not compliant

## Quality and safety

Six regulations were inspected against relating to *quality and safety* and overall, the inspectors found mixed levels of compliance across these areas. Four regulations were found not to be compliant while one regulation was substantially compliant and one further regulation was in full compliance. Areas requiring improvement included the premises of the centre and the provision of individual bedrooms to residents, risk management, fire safety and precautions, and medication management.

The inspectors found that overall, the centre was homely, tastefully decorated to meet the wishes of residents, and clean throughout. The design and layout of the premises of the centre ensured that residents had opportunity to live in an accessible and safe environment. In one unit of the centre the external area of the property required painting. Six residents were found to be sharing three bedrooms in the centre and while the registered provider was aware of this matter, the sharing of bedrooms had recently contributed to a complaint received by the provider and also featured in the completed questionnaires received by the inspectors.

The inspectors found that residents were supported to achieve and maintain the best possible health. There was timely access to medical professionals through primary care and specialist services. There were a wide variety of allied health professional services available within the organisation to support residents' needs including psychology, social work, psychiatry, occupational therapy, speech and language therapy, physiotherapy and nursing. In addition, residents were found to

have been supported externally by general practice, endocrinology, neurology, dietetics, dental and chiropody services.

Risk management systems in place in the centre were found not to be satisfactory. The inspectors found that identified risks were not appropriately assessed by the registered provider and in some instances not all obvious risks had been assessed. A review of incident, accident and near miss records found evidence of mixed response and follow up to incidents. In the case of incidents such as medication errors and slips, trips and falls, the inspectors found that there had been appropriate follow up actions taken, however, in the cases of allegations of abuse the inspectors found that appropriate follow up action had not been taken in the cases of four of eight incidents identified.

A review of fire precautions in the centre found that significant areas of improvement were required to bring this area into compliance with the regulations. While there were some fire containment measures in place, the inspectors found that these were inconsistently applied and did not protect all exit routes. Closing mechanisms were not in place on some fire doors, there was an absence of fire containment measures protecting central hallway and stairwell areas, and the doors in place to attic spaces were found not to have been fire rated. In addition, an emergency fire exit door was found to have been locked and no key was available in a break glass unit. Emergency lighting was not in place in all required areas and fire doors in place in the centre were not inspected as required by organisational policy on a six monthly basis. A review of fire drill records found that there was contradictory information documented and personal emergency evacuation plans did not provide clear information on the supports required by residents in the event of an emergency. Fire evacuation procedures were not on display in all units of the centre and while there was a plan of the centre on display, this did not outline emergency fire exits.

A review of medication management arrangements found that keys for medication cabinets were not securely stored in two units of the centre. There were no expiry dates present on a number of regular and PRN medications (medication taken as the need arises). In addition, there were no expiry dates available for medication contained in blister pack systems in use. In one unit, out-of-date medication was present in a resident's medication pack. Medication administration records were found to be poorly maintained in some instances and times of administration were not available in the cases of two residents records reviewed. In the case of another resident, records did not specify timed of administration and instead referred to ''breakfast time'' and ''dinner time''. While PRN medications prescribed for residents were found to include the maximum doses that could be administered in a 24 hour period and the criteria for administration, there was a lack of clarity with regards to the period of time that should be allowed for between administrations. The inspectors found that staff knowledge relating to the administration of emergency medication to resident was not satisfactory.

Residents availing of the services of the centre informed the inspectors that they felt safe and were knowledgeable of what to do if they ever felt unsafe or at risk. Staff spoken with by the inspectors were aware of what constituted abuse and the

appropriate actions to take in response to concerns, allegations or suspicions of abuse. A review of incident, accident and near miss records found that eight incidents of alleged abusive interactions occurred in the time period reviewed. It was found that four of the eight incidents identified by the inspectors had not been responded to or followed up on in line with procedures outlines in the *Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014)* document.

## Regulation 17: Premises

In one unit of the centre the external area of the property required painting. Individualised bedrooms were not available to all residents availing of the services of the centre.

Judgment: Not compliant

## Regulation 26: Risk management procedures

The inspectors found that identified risks were not appropriately assessed by the registered provider and in some instances not all obvious risks had been assessed. Appropriate follow up action had not been taken in the cases of four of eight incidents identified relating to alleged abusive interactions.

Judgment: Not compliant

## Regulation 28: Fire precautions

While there were some fire containment measures in place, the inspectors found that these were inconsistently applied and did not protect all exit routes. An emergency fire exit door was found to have been locked and no key was available in a break glass unit. Emergency lighting was not in place in all required areas and fire doors in place in the centre were not inspected as required by organisational policy on a six monthly basis. A review of fire drill records found that there were contradictory information documented and personal emergency evacuation plans did not provide clear information on the supports required by residents in the event of an emergency. Fire evacuation procedures were not on display in all units of the centre and while there was a plan of the centre on display, this did not outline emergency fire exits.

Judgment: Not compliant

## Regulation 6: Health care

Residents were found to have been supported to achieve and maintain the best possible health. There was evidence of timely access to medical and allied health professionals when required.

Judgment: Compliant

## Regulation 8: Protection

It was found that four of the eight allegedly abusive incidents identified by the inspectors had not been responded to or followed up on in line with procedures outlines in the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014) document.

Judgment: Substantially compliant

## Regulation 29: Medicines and pharmaceutical services

Keys for medication cabinets were not securely stored in two units of the centre. Staff members were unable to confirm that some medication contained in their medication cabinet were within expiry dates. Out-of-date medication was present in a resident's medication pack. Medication administration records were found to be poorly maintained in some instances and times of administration were not available. There was a lack of clarity with regards to the period of time that should be allowed for between administrations of PRN medications. The inspectors found that staff knowledge relating to the administration of emergency medication to resident was not satisfactory.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 24: Admissions and contract for the provision of services | Substantially compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Substantially compliant |
| Regulation 29: Medicines and pharmaceutical services | Not compliant |

# Compliance Plan for Glenageary OSV-0003578

## Inspection ID: MON-0021797

## Date of inspection: 18/07/2018

### 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:<br><br>One of the houses in this designated was identified as needing additional staff. This house currently has additional staff on two evenings. Additional staff will be allocated to this house to ensure they have additional cover for at least 3 evenings per week.<br><br>The Social Care Leader will check with the staff team on a weekly basis to review the plans for the residents for the week. If an additional outing/activity has been chosen by the residents (and it falls outside of the allocated 3 evenings per week) the Person in Charge will ensure that an additional staff will be on duty to facilitate this.<br><br>As two of the ladies regularly go home for the weekend there will be no planned additional cover for the weekend. If on occasion all the ladies decide they want to stay in their home for the weekend the person in charge will ensure that there is additional cover available.<br><br>Timeline: 5th November 2018<br>Person Responsible: Person in Charge<br><br>There is now a duty roster and a planned roster in place. Previously the roster had the names of the individual houses – however going forward the roster now has the name of the DC on them.<br><br>Timeline: 5th November 2018<br><br>Person responsible: Michelle Genoe | |
| Regulation 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and | |

staff development:

All staff are now up to date in all areas of mandatory training. This will be reviewed on a monthly basis with the Person in Charge. Additional training has also been offered to staff in the areas of communication and skills teaching.

A schedule of supervision is now in place and all staff, permanent and relief will receive supervision every three months as per their supervision contract.

Timeline: 22nd October 2018

Person Responsible: Person in Charge and the Social Care Leader

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|---|---|
| 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:

The resident and their family will sign all contracts of care by the 30th of November. This will be done through circle of support meetings for each of the 6 individuals who currently do not have their contract of care signed. The keyworker will facilitate these meetings ensuring that all relevant people, according with the individuals wishes, are invited.

Timeline: 30th November 2018

Person Responsible: Keyworker with support from the Social Care Leader

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| Regulation 3: Statement of purpose | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The statement of purpose will be amended by the person in charge and sent to the regulator by the 6th of November.

Timeline: 6th of November 2018

Person Responsible: Person in Charge

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|---|---|
| Regulation 34: Complaints procedure | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The Person in Charge will do a complete review of the complaints folder and identify areas where complaints have not been resolved. Where there are complaints still outstanding the person in charge will meet with the individuals involved and explore the

complaint with them. If the complaint is still an issue for the individual the person in charge will reopen the complaint and attempt to resolve it via the complaints policy.

The complaints register will be reviewed and updated on a monthly basis by the social care leader and the person in charge.

Timeline: December 20th 2018

Person Responsible: Person in Charge

| Regulation 4: Written policies and procedures | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

The Person in Charge will ensure that the reviewed policies are put into the schedule 5 folder in each area and discussed at the team meeting.

The Person in Charge will ensure the policy folder is audited every 6 months and all policies are up to date.

Timeline: November 30th 2018

Person Responsible: Person in Charge

| Regulation 23: Governance and management | Not Compliant |
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Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Person in Charge shall ensure that internal audits relating to Fire Safety are in line with national policy relating to the designated Centre. This information will also be fed to our internal auditing team to ensure they are also auditing in lines with best practice in this area. This will ensure that we are correctly self identifying areas of risk and non compliances within the regulations.

Timeline: 2nd November 2018

Person Responsible: Person in Charge

| Regulation 17: Premises | Not Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:

On of the houses was identified as needing to be painted at the back.

Timeline: December 22nd 2019

Person Responsible: Person in Charge.

Glenageary designated Centre has a shared bedroom in all three houses.

There are plans in place for one resident to move to a new designated Centre in the Summer of 2019 when a bedroom becomes available. There is a transition plan already in place for this individual. The move is contingent on the residents consent to move. The person charge will ensure that the resident and their family has every opportunity to visit and become familiar with the centre and understands what it means to move to a new home and the positive impact we believe this will have on their future. An independent advocate will be engaged with to ensure that the individuals voice is heard in relation to this move.

Timeline: 31st August 2019

Person responsible: Person in Charge

The residents in another of the houses have already been offered a move to a new location but both the residents and their families refused this move as they wanted to continue living in this house. They clearly voiced to staff and management that this was the persons home and they did not want to live anywhere else. The possibility of putting an additional bedroom in this house was explored extensively. However this is not a possibility. As new places become available in the service the residents will be offered the opportunity to move and have their own bedroom.

The shared bedroom in the third house is being reviewed on a quarterly basis via the residential planning group. When a space becomes available suitable to the needs of the ladies they will be offered their own room in another house.

The shared bedrooms is high on the agenda for this designated centre and something the person in charge and the residential management team are aware of and trying to resolve. All three of these shared bedrooms are reviewed at least quarterly by the residential planning group and as suitable places arise they will be offered to the individuals currently sharing a bedroom. When a place arises it will be discussed with the individual via the circle of support meetings and a transition plan will be put in place for the individual. An independent advocate will be sourced for the individual, to enable the resident to communicate their wishes and to ensure we are clearly hearing their voice throughout the process. The moves will only happen with the individuals consent.

Timeline: Reviewed on a quarterly basis via the residential planning group

Person Responsible: Person in Charge

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|---|---|
| Regulation 26: Risk management procedures | Not Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The Person in Charge and Social care leader will meet with all keyworkers to review risk in this Designated Centre. All areas of risk will be reviewed and rated in accordance with statistics based on the data collected for the Designated Centre.

Timeline: 28th December 2018

Person Responsible: Person in Charge and Social Care Leader

All incidents relating to abusive interactions will be reported through our safeguarding process in line with National Policy. All incidents reported through the safeguarding process will be reported as a 3 day notifiable event to HIQA.
All incidents/Safeguarding will be reviewed at the weekly team meeting and at the weekly meeting between the Social Care Leader and Person in Charge.
All staff have received safeguarding training.

Timeline: 19/07/18

Person Responsible: Person in Charge

| Regulation 28: Fire precautions | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Break Glass units: The emergency exit identified now has a break glass unit containing the key in the event of an emergency.

Timeline: 22/10/18

It was found that there was not emergency lighting in place that lit the area to the emergency exit. The person in charge will ensure that this lighting is put in place in all areas.

Timeline: March 7th 2019

Person Responsible: Person in Charge

A qualified Fire Engineer will be sourced to assess current fire containment measures in place in this designated Centre and to advise as to what additional fire containment measures are needed. This will include the assessing what is needed to protect the central hall and stairwell and the attic doors. The person in charge will ensure this assessment is carried out by December 22nd 2018 and will act on recommendations as appropriate.

Timeline: December 22nd 2018

Person Responsible: Person in Charge

A new fire register is being implemented in all houses in this designated centre and all

staff will be inducted onto their use. The fire doors will be checked by staff on a monthly basis and there are clear directions about how to do this in the fire register.

Timeline: January 31st 2019

Person Responsible: Person in Charge

The person in charge will ensure that the closing mechanisms on all fire doors are working correctly in each house.

Timeline: November 20th 2018

Person Responsible: Person in Charge

All Personal evacuation plans will be updated to ensure the information on fire evacuation for the individual is clear and easy to access. All personal evacuation plans will be reviewed after each fire drill and updated as required. Each fire drill will be discussed with the team to ensure that there is learning for each fire drill.

Timeline: November 9th 2018

Person Responsible: Person in Charge

All emergency plans will clearly outline the exit routes in the event of fire

Timeline: 5th of November 2018

Person Responsible: Person in Charge

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

All incidents relating to abusive interactions will be reported through our safeguarding process in line with National Policy. All incidents reported through the safeguarding process will be reported as a 3 day notifiable event to HIQA.
All incidents/Safeguarding will be reviewed at the weekly team meeting and at the weekly meeting between the Social Care Leader and Person in Charge.
All staff have received safeguarding training.

Timeline: 19/07/18

Person Responsible: Person in Charge

| Regulation 29: Medicines and pharmaceutical services | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

A keypad has been installed in the office for the safekeeping of keys for the medication cabinet.

Timeline: 05/11/18

Person Responsible: Person in Charge

A PRN protocol will be written for all PRN medication indicating the usage of the medication – including how, why and when to take it, including the period of time that should be allowed for between administrations.

A new recording system for the administration of medication in the centre will be introduced. The person in charge will ensure that all staff are inducted into this system.

A stock take for all medications will take place weekly, before the new intake of medication, to ensure there is no overstocking of medication and no out of date medication. A medication audit will also be undertaken quarterly in each house.

All staff working in this house are now familiar with the residents epilepsy plan and emergency medication associated with it. This has been discussed individually with all staff to ensure everyone knows the correct dosage and timing of the medication.

Timeline: 20th December 2018

Person Responsible: Person in Charge

## 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 |
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| 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 | 5/11/18 |
| 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 | 05/11/18 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including | Not Compliant | Orange | 22/10/18 |

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| | refresher training, as part of a continuous professional development programme. | | | |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 22/10/18 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 22/12/19 |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Not Compliant | Orange | 31/08/19 |
| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any | Not Compliant | Orange | 02/11/18 |

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| | concerns regarding the standard of care and support. | | | |
| Regulation 24(3) | The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre. | Substantially Compliant | Yellow | 30/11/18 |
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. | Not Compliant | Orange | 28/12/19 |
| Regulation 28(2)(c) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 07/02/19 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 22/12/18 |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where | Not Compliant | Orange | 09/11/18 |

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| | necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | | | |
| Regulation 28(4)(b) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Not Compliant | Orange | 09/11/18 |
| Regulation 28(5) | The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre. | Not Compliant | Orange | 17/07/18 |
| Regulation 29(4)(a) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is | Not Compliant | Orange | 20/12/18 |

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| | kept in the designated centre is stored securely. | | | |
| Regulation 29(4)(b) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident. | Not Compliant | Orange | 20/12/18 |
| Regulation 29(4)(c) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products | Not Compliant | Orange | 20/12/18 |

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| | in accordance with any relevant national legislation or guidance. | | | |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 05/11/18 |
| Regulation 34(2)(d) | The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process. | Substantially Compliant | Yellow | 20/12/18 |
| Regulation 34(2)(f) | The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied. | Substantially Compliant | Yellow | 30/10/18 |
| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where | Substantially Compliant | Yellow | 30/11/18 |

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| | necessary, review and update them in accordance with best practice. | | | |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 19/07/18 |
| Regulation 08(3) | The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse. | Substantially Compliant | Yellow | 19/07/18 |