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

Issued by the Chief Inspector

Name of designated centre:	Telford Houses & Apartments
Name of provider:	St Mary's Centre (Telford)
Address of centre:	Dublin 4
Type of inspection:	Unannounced
Date of inspection:	27 November 2019
Centre ID:	OSV-0002314
Fieldwork ID:	MON-0024083

About the designated centre

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

The designated centre is located on a shared campus in South Dublin which provides services for persons with disabilities and to older persons through two nursing home units on the site. It is made up of three semi-detached houses and 10 apartments and supports residents with a wide range of needs through residential services. Primarily residents have diagnoses of visual impairments, however, support needs include communication difficulties, mild intellectual disabilities, and psychological and mental health needs. The staff team is comprised of a person in charge and care attendants with a total whole time equivalent of 8.0.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	22

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 27 November 2019	10:00hrs to 18:15hrs	Thomas Hogan	Lead
Wednesday 27 November 2019	10:00hrs to 18:15hrs	Amy McGrath	Support

What residents told us and what inspectors observed

The inspectors met with a number of residents who were availing of the services of the centre and observed care and support interactions. Overall, residents expressed satisfaction with the services they were in receipt of, however, some residents expressed concerns about the follow up to complaints made and the physical environment of the centre. The inspectors observed that residents were supported by staff in a timely manner and that interactions from staff members were kind and respectful.

Capacity and capability

The inspectors found high levels of non-compliance across many of the regulations inspected against during this inspection. Overall, the registered provider was found to have failed to ensure that services being provided were safe, consistent and effectively monitored. The centre was not appropriately resourced to ensure the effective delivery of care or to meet the needs of residents availing of its services. There were significant concerns identified relating to fire safety and immediate actions were issued to the provider to address these as a matter of urgency. In addition, the inspectors found that there were a range of non-compliances in areas such as the governance and management of the centre, staffing, the training and development of the staff team, the management of complaints, risk management, the completion of assessments and personal plans, and the protection and safeguarding of residents.

The inspectors found that there had been changes in the individuals holding the position of person in charge since the time of the last inspection. The registered provider failed to supply full and satisfactory information to the office of the chief inspector in regard the individual who was holding the position of person in charge until November 2019 despite a number of requests being made to do so. The office of the chief inspector was not notified within 10 days of the change in person in charge. In addition, the inspectors found that the registered provider had not notified the office of the chief inspector of the proposed change to the identity of a general manager or provided full and satisfactory information in respect of this person.

The person in charge was met with by the inspectors as part of this inspection. While the inspectors found that the person in charge met the requirements set out in the Regulations, the individual was unsure whether they held the role of person in charge or not. The inspectors also found that the general manager for the organisation was unsure of who held this position and the centre's statement of purpose provided conflicting information about this and other governance and

management structural matters.

The inspectors reviewed the centre's staffing arrangements and found that the number of staff members employed in the centre was not sufficient to meet the needs of residents. The staff team was made of seven care attendants who were supported by a supernumerary person in charge and the inspectors found that there was evidence that the skill mix of this team was not appropriate to meet the presenting needs of residents. For example, a number of residents presented with mental health needs, however, representatives of the registered provider informed the inspectors that they were unable to appropriately support these residents. The inspectors observed that the skill mix of the staff team did not allow for appropriate supports for some residents with matters such as self-care and behaviour support.

A review of staff duty rosters found that planned and actual rosters were not maintained as required by the regulations. A sample of six staff files were reviewed by the inspectors and it was found that in two cases there were unexplained gaps in the employment history of the staff members. In addition, there were issues identified with references for two staff members. In one case a staff member did not have any reference from a previous employer as required, despite having a number of previous employers and in the second case the employee had only one signed reference on file.

The inspectors reviewed available staff training records and found that in a number of cases, training described as being 'mandatory' by the registered provider had deficits in completion rates by members of the staff team in a number of areas. Despite requesting full records of training from the registered provider, only partial records were made available to the inspectors during the course of the inspection. A review of the arrangements for the supervision of staff members was completed by the inspectors and found that there was an absence of clear guidance or policy on this matter in the centre. A sample of staff supervision records reviewed by the inspectors found that one-to-one supervision meetings between staff members and a manager were completed only once every 12 months on average. As a result, the inspectors found that the staff team employed in the centre were not appropriately supervised.

The arrangements for the governance and management of the centre were reviewed by the inspectors. As previously mentioned, the governance structure of the centre was unclear amongst the senior management team. There was conflicting information regarding the make up of the management team of the centre being presented through the centre's statement of purpose, from the management team present on the day, and from staff members. An annual review of the centre had not been completed for 2018 and the last six monthly unannounced visit to the centre by a representative of the registered provider was completed in October 2018. There was little oversight of the care and support being provided to residents and as a result the management team were not aware of issues which had arisen. The inspectors found that the registered provider had failed to ensure that there were sufficient resources in place to ensure that appropriate care and support could be delivered to all residents.

The provider had prepared a contract of care for each resident, which outlined the terms on which they would reside in the centre. The inspectors found that these contracts did not clearly outline the care and support provided to residents, or the services to which fees were applied. It was found that residents could choose between a number of payment options, including a rent only arrangement, and a higher payment to include food and heat. These arrangements represented substantially different rates, and it was not clear what the breakdown of the additional fee covered. The contract of care did not clearly outline the arrangements for the provision of food; inspectors found that residents were required to eat meals in a communal dining hall, which was not reflected in the contract of care. The care agreements required review to ensure that residents were fully informed in order to enter into these contracts.

Inspectors found that some residents paid their full weekly pension to the centre, and in some cases this arrangement placed limitations on the residents ability to make choices about their daily care and support. For example, one resident who paid 'full fees' was found not to have food in their fridge, and had just cereal and crisps in their press. This person, who had a visual impairment, was required to walk to the main dining hall for meals, or request staff to bring a meal over to their home. Improvements were required to ensure that arrangements facilitated residents to make choices about the service they received.

It was also found that the admissions procedures were not consistently applied as per the statement of purpose. For example, a review of contracts found that the centre accepted referrals from private and publicly funded individuals. It was also found that some residents did not require support for a disability as outlined in the statement of purpose.

The inspectors reviewed the arrangements in place for the management and support of volunteers. There were four volunteers supporting the centre on occasions and all had Garda vetting completed and on file. Volunteers were found to have their roles and responsibilities set out in writing and to receive support and supervision on occasion from the person in charge. Overall, the inspectors found that there were appropriate arrangements in place in this regard.

A review of accident, incident, near miss and complaints records was completed by the inspectors. Three incidents were identified through this process which involved alleged safeguarding concerns relating to residents. None of the three incidents had been notified to the Office of the Chief Inspector as required by the Regulations.

The inspectors reviewed the arrangements in place for the management of complaints in the centre and found that these were not effective. There had been a significant number of complaints made in the centre and the inspectors found that these had not been investigated or followed up on and the residents making the complaints had not been informed of the outcome. The inspectors were not assured that the senior management team understood their role in the management of complaints and found that the centre's policy on complaints management had not been followed or implemented in practice. During a discussion on this matter with

representatives of the registered provider, the inspectors were informed that some complaints were to be disregarded as the persons making them presented with mental health difficulties.

Registration Regulation 7: Changes to information supplied for registration purposes

The inspectors found that the registered provider had not submitted required information to the office of the chief inspector regarding the person in charge of the centre up to November 2019. The registered provider had not notified the office of the chief inspector of the appointment of this person in charge in line with the required time frames. The proposed change to a general manager had not been notified along with required information relating to this individual not being submitted as required.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge of the centre was unclear whether they had been appointed as person in charge or not. A general manager, who represented the registered provider, was not aware who the person in charge of the centre was at the time of the inspection.

Judgment: Not compliant

Regulation 15: Staffing

The inspectors found that the numbers of staff members employed in the centre was not sufficient to meet the needs of residents. The skill mix of the staff team was also found not to be appropriate to meet the needs of some residents. Planned and actual staff duty rosters were not maintained in the centre. A review of a sample of staff files found that some information identified as being required by Schedule 2 of the Regulations had not been obtained.

Judgment: Not compliant

Regulation 16: Training and staff development

Complete records relating to staff training were not made available to the inspectors during the course of the inspection despite a request being made for them. From records which were available, the inspectors found that mandatory training programmes were not completed by all members of the staff team. Appropriate arrangements for the supervision of the staff team were not in place in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The centre was found to be insufficiently resourced to allow for the effective delivery of care to residents. The management structure was not clearly defined and amongst others, the management team were not aware of who was responsible for the management of the centre. There was an absence of effective management systems to ensure that services provided were safe, appropriate to meet the needs of residents, consistent and effectively monitored. An annual review had not been completed in 2018 and a six monthly unannounced visit had not been completed since October 2018.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

It was found that the arrangements in place for admission to the centre were not based on transparent criteria, and that admissions were not consistently in line with the statement of purpose. While the provider had ensured that residents had agreed in writing to the terms on which they reside in the centre, it was found that these contracts did not clearly outline the care and support to be provided. Furthermore, the contracts of care did not contain sufficient information of additional fees that were potentially payable by residents.

Judgment: Not compliant

Regulation 30: Volunteers

There were appropriate arrangements in place in the centre for managing and supporting volunteers and there was clear evidence that volunteers supported residents to live a more active and meaningful life.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspectors found that notifications had not been made to the Office of the Chief Inspector as required in the case of alleged safeguarding concerns which arose in the centre on three occasions and involved residents.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider failed to ensure that there was en effective complaints process in place for residents. Complaints made in the centre had not been investigated or followed up on. The complaints management policy was not implemented in practice and residents were not informed of the outcome of the complaints process.

Judgment: Not compliant

Quality and safety

A full walk through of the premises of the designated centre was completed by the inspectors in the company of the person in charge. Overall, it was found that the design and layout of the centre was appropriate to meet the needs of residents, however, there were improvements required in a number of areas in relation to cleanliness and general maintenance. In some areas, the inspectors found that there was malodour and significant amounts of pet hair. In other areas rooms were observed to be cluttered and some furniture items was noted to be in a worn and damaged state. In one apartment the inspectors observed a staff member removing a considerable amount of dirt and tobacco from a floor which had not been cleaned in a number of days. In another apartment, the inspectors were not assured that there were appropriate arrangements in place for heating the space.

The inspectors reviewed the centre's risk management systems and found that appropriate arrangements were not in place. While there was a risk register maintained in the centre, there was evidence to demonstrate that this had not been updated since an unspecified date in 2017. The risks outlined in this document did not include those relating to residents and as a result the inspectors found that there was limited oversight of risk management. In addition, the inspectors found

that risk rating attributed to risks within the risk register were not appropriate and some control measures listed were not in place. For example, risks relating to fire safety were rated as 'medium' risks, however, the inspectors found serious risks in this area which the registered provider had not identified or addressed. The inspectors found that the management team had limited awareness of the risks presenting in the centre or the measures which were in place to control risks. There was a risk management policy in place (dated August 2018) which was reviewed by the inspectors. It was found that there were two areas outlined as being required by the Regulations which were not contained in the document.

A review of the centre's fire precautions was completed by the inspectors who found that there were significant concerns in this area. The centre had no fire containment measures in any area and had no plans for the completion of works to address this failure. While there was a fire alarm and detection system and emergency lighting in place, there was no evidence of its service or maintenance. In the case of the emergency lighting, the last record of service or maintenance competed in the centre was August 2017. The inspectors found that there was only one fire extinguisher available in each of the three houses and none available within each of the ten apartments. The only fire fighting equipment available in the apartments were fire blankets and in nine of the ten apartments the inspectors found that these had not been serviced or maintained since January 2018. A review of fire drill records found that a number of residents had not participated in fire drill exercises in a number of years. The inspectors also found that there had been no night-time drills completed and as a result were not assured that all 22 residents could be evacuated safely at night by one sleep over staff member. Personal emergency evacuation plans did not clearly outline the individual supports required by residents in the event of a fire or similar emergency. The inspectors issued an immediate action to the registered provider relating to fire safety during the course of the inspection and on the day after the inspection issued a written second specific immediate action in relation to the evacuation of residents during a fire.

The inspectors reviewed the assessments of need and personal plans in place for residents. Assessments completed were not comprehensive and were not carried out on at least an annual basis. In the case of some residents, assessments had not been completed since 2017. It was not clear what the needs of residents were from reviewing them and in the cases of some residents the assessments highlighted that there were no support needs identified. In some instances, there was clear evidence to demonstrate that registered provider had not put in place arrangements to meet the needs of residents. For example, residents who presented with mental health needs were not appropriately supported with associated behaviours.

A review of the arrangements in place in the centre to protect and safeguard residents from experiencing abuse was completed by the inspectors. Overall, residents were found to experience few incidents of a safeguarding nature, however, when such incidents did occur, the inspectors found that they were not managed in line with national policy on this matter and the management team had limited awareness of the expected response. There was evidence of incidents of safeguarding nature being managed through a complaints process and no follow up action being taken in line with the *Safeguarding Vulnerable Persons at Risk of Abuse*

- *National Policy and Procedures* (Health Service Executive, 2014).

Regulation 17: Premises

Improvements were required in a number of areas of the premises of the centre including a deep clean, heating of some areas, and upgrading of furniture and fittings.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspectors found that there was an absence of developed or reliable systems for the management of risk in the centre. As a result there was poor oversight of risk and limited awareness of the matter by the management team. The centre's risk management policy (dated August 2018) was found not to contain two areas identified as being required by the Regulations.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors found that the centre did not have appropriate fire precautions in place. There was an absence of fire fighting equipment in the centre and while there were fire alarm and detection systems and emergency lighting there was an absence of evidence of the regular maintenance and servicing of these. There was an absence of evidence to demonstrate that one sleep over staff member could successfully evacuate all 22 residents from the centre at night time in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Assessments of need completed for residents were not comprehensive and were not carried out on at least an annual basis. It was not clear what needs were arising from completed assessments, and in some instances there were no needs identified through the process. The registered provider failed to ensure that arrangements

were in place to meet the needs of some residents.

Judgment: Not compliant

Regulation 8: Protection

Incidents of a safeguarding nature which occurred in the centre were not managed, as required, in line with national policy. The national policy was not implemented in practice in the centre and the management team had little awareness of the requirements outlined in this document.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Telford Houses & Apartments OSV-0002314

Inspection ID: MON-0024083

Date of inspection: 27/11/2019

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
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: • Following resignation of General Manager (leaving for new role) and extended absence for illness of Administration Manager a lack of detailed procedural knowledge on notification of information caused delays and errors which have now been substantially corrected. Appointment of a temporary replacement General Manager on 27 September 2019, phased return to work of Administration Manager from 16 December 2019, and appointment of Director acting as nominee registered provider have all resulted in improvements in notification processes and these will be complete before 31 December 2019. • Registration Reg. 7(2): Correct PIC appointment/replacement now notified. • Registration Reg. 7(4): Changes to Directors (two appointments), General Manager, PPIM and Director acting as nominee registered provider will all be correctly notified before 31 December 2019. This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.	
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in	

charge:
• The permanently-appointed PIC for the Centre meets all qualification requirements set out in the Regulations, and has been correctly notified to HIQA.
• The replacement PIC in place to cover maternity leave was correctly notified to HIQA, but she was replaced for a temporary period by (former PIC for the centre) to meet all qualification requirements. The situation was resolved correctly and permanently when PIC returned from maternity leave in October 2019. Having previously been PIC in an "acting up" capacity she was appointed as permanent PIC when she assumed the role from replacement PIC at that time. Any uncertainty resulting from the notification procedure has been fully resolved.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• Total number of required staff and their required skills will be confirmed via a revised assessment of residents' needs, which will be complete by 31 January 2020. This revised assessment will cover disability needs, nursing needs, self-care needs, mental health needs and behaviour support. Assessment forms will be amended, completed and summarized to clearly identify the needs and related care skills required by each resident.
• Any identified changes that are required to the team of care staff will be confirmed with HSE following completion of the residents' needs assessment, and will then be implemented by the PIC and General Manager in February 2020, so that the size of the team (capacity) and its skills base (capability) will meet identified needs of residents.
• Planned and actual staff duty rosters are maintained, are available at all times and updated as circumstantial changes arise.
• Staff files will be audited and updated to ensure all information required by the Regulations is included. Particular attention will be paid to outstanding references and to ensure the files include all work history for each staff member. This will be completed by 28 February 2020.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• PIC has now received updated training on access to real-time staff training records and the use of these to ensure mandatory staff training is completed by all staff within the timeline laid out in the staff training plan. All outstanding mandatory training

requirements for staff will be carried out by 28 February 2020.
• Training and Development Policy and Detailed Plan will be reviewed and updated by 28th February 2020. This will include, in particular:
o Fire Safety Training scheduled to be fully complete by January 2020.
o Positive Behaviour Management Training for staff team to be scheduled for completion by 30 June 2020.
o Outstanding Safeguarding Training to be completed by 31 January 2020.
• Based on feedback and observations from staff the PIC will identify and organise any additional training requirements by 30 June 2020.
• PIC will carry out supervision session with all staff by 31 January 2020, in which PDR will be conducted and required actions will be identified. Thereafter regular quarterly supervision sessions will be scheduled in March, June, September and December 2020.
• Supervision Policy will be reviewed, amended, approved by the Board and published by 28 February 2020.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Any confusion regarding governance and management of the centre resulted from personnel changes (General Manager, PIC) that had occurred in the month prior to the review. These changes are now fully embedded and operational, and any confusion has been removed.
• The Board will approve the current management structure and operation of the centre by 28 February 2020, including roles, authority and accountability for service provision. This will be confirmed to all management employees following Board approval.
• Formal nomination of a Director acting as nominee registered provider has been approved by the Board and this will be notified to HIQA by 31 December 2019.
• An Annual Review of the centre for 2019, carried out by a representative of the registered provider, will be completed by 28 February 2020. This will also cover 2018 (for this year only as a review for that year was not completed).
• 6-monthly reports for the centre during 2020 will be completed by 28 February 2020 and 31 August 2021.
• The centre’s Statement of Purpose will be fully updated by 15 January 2020, and will be maintained on a timely basis from that point. The Board will review the Statement of Purpose by 28 February 2020 to ensure that services provided meet the needs of residents and that they are monitored through the action of Board subcommittees and through the annual review.
• The Board will ensure that a calendar is in operation for all working Board subcommittees by 31 January 2020. Each subcommittee chairman will report to the next Board meeting following completion of the subcommittee meeting and will explain outstanding issues and agreed actions under implementation.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• Admissions Policy will be reviewed, amended and approved by the Board by 28 February 2020.
• Admissions procedures for existing residents will be reviewed and any exceptions from the standard admissions policy will be investigated and explained by 31 March 2020.
• Current Contract of Care will be reviewed, amended and approved by 28 February 2020 to ensure clear, adequate and correct detail on care and support offered, together with a simplified explanation of the fee structure and the services to which this applies.
• The PIC will speak to each resident to ensure they understand the service and choice options contained in their contract of care and that they are satisfied with these. This will be complete by 28 February 2020 and will be documented on their files. Any alterations identified as being required to individual contracts in order to ensure fair and equitable treatment of each resident in accordance with their needs and wishes will be completed by that date.
• Statement of Purpose and Function will be reviewed and amended to ensure all aspects as required by regulations are included. To be completed by 28th February 2020
• Residents Guide will be reviewed and updated by 28th February 2020, to ensure it includes all required information for residents and potential residents.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Policy on incident reporting to be reviewed and updated by 28th February 2020
• PIC and staff attended Safeguarding training on the 6/12/19.

• All incidents reported are on the online system, which means that PIC and Senior management have access. PIC had MTD meeting on 12/12/19 with staff and discussed all reported incidents in 2019. It was explained to staff that three incidents involved safeguarding, and all safeguarding incidents need to be notified to the Office of the Chief Inspector.
• Regular MTD meetings will be held at 6 weekly intervals in 2020 and any incidents arising in this time will be discussed to ensure that response and notification are correctly managed, and learning lessons will be noted in the meeting minutes.
• Incidents shall also be reviewed at management team meetings during the year.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints policy to be reviewed and updated by 31 January 2020.
• Simplified version to be circulated in all houses and apartments and PIC will discuss with residents at a residents meeting in January 2020.
• Staff were reminded 12 December 2019 that all residents' complaints must be investigated, and the resolution must be documented and communicated to the complainant.
• PIC is following up on all outstanding complaints and will have completed by 24 December 2019 including reverting back to resident who complained to ensure satisfaction with outcome or other feedback they may have to share.
• Going forward all complaints shall be followed up in line with our complaints policy.
• PIC will organize a training session for staff in January 2020 on procedure to be followed for managing complaints.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Audit of Maintenance Issues for Houses and Apts conducted 6 December 2019.
• Some furniture replaced 5 December 2019.
• Painting for kitchens in Houses is scheduled to commence on January 6 2020.
• Flooring replacement requirements noted and budgetary considerations being examined so a schedule of replacement may be devised for completion of works in 2020.
• Burglar alarms in houses being connected to staff mobile phone to avoiding need for third party informing staff of activation: to be completed by 31 January 2020.
• Fire alarms activation to be connected to staff mobile phone avoiding need for third party notification. To be completed by 31 January 2020.

• PIC has requested changes in cleaning procedures from contractor, to include increased hours, use of weekdays only for cleaning and tighter review procedures. Contractor will revert with detailed proposal in January 2020.
• Currently any faulty heaters are being identified and replaced with new ones.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Risk Register to be reviewed and updated by 28 February 2020.
• Risk Management Policy to be reviewed and updated ensuring it contains all relevant items as outlined the regulations. This will be completed by 31 January 2020.
• Individual risk assessments in residents' care plans to be updated by PIC by 15 January 2020.
• Risks/Hazards on the agenda for discussion at regular MTD meetings.
• Risks/Hazards discussed at Quality and Safety meeting to be held in January 2020.
• Emergency plan to be reviewed by 28 February 2020.
• Manager is on call each week as a point of contact for staff in case of emergencies, with phone numbers listed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Audit of fire safety matters was conducted by BRK Fire & Safety Consultants in Nov/Dec 2019 and their letter of 5 December 2019 (previously forwarded to HIQA) confirmed:
o Fire Safety training was provided to the care staff at the Designated Care centre in March 2019 and in July 2019 by BRK. Fire evacuation drills were also carried out by BRK in March 2019 and in July 2019.
o BRK visited all apartments and houses in Dec 2019 and confirmed that residents in the apartments are all very active, very capable, co-operative in fire evacuation drills and capable of self-evacuation. Test evacuations were carried out by them during their visit and proceeded without difficulty, all residents self-evacuated and all procedures were satisfactorily adopted.
o The current suite of fire safety measures taken include (a) at least LD2 standard automatic fire detection and alarm (b) emergency lighting (c) fire extinguishers to I.S. 291:2015 (d) fire safety training of staff (e) and regular fire evacuation drills (which in the case of Telford does include the residents).

o The internal doors off the stairs in each of the three houses were fitted as twenty-minute fire door leaves with the kitchen door fitted as a sixty-minute fire door leaf. The provision of self-closing devices is not a requirement for domestic dwellings and their provision is subject to risk assessment for existing care premises where a self-closing door may introduce impact injuries. This fire safety strategy has been determined by the fact that each house is a self-contained semi-detached house occupied on a shared basis. The occupants are familiar with the premises as configured.
o The provision of self-closers to the fire doors, and other fire safety precautions, will remain under review to monitor if circumstances arise which require their provision.
o Service and maintenance of fire alarm and detection system and emergency lighting was carried out in week ending 4 Dec 2019. Records are now on the wall beside the fire alarms. Copies have now been put in the fire register also.
o Service and maintenance of fire equipment was carried out in week ending 4 Dec 2019. Copies are now in the fire register.
o The current provision of overnight staff is for a single person to sleep in House 2, where the two residents who require prompting to evacuate are resident. Also, at night there are two security staff, one of whom remains at reception and the second who carries out rounds and would be directed to go and assist with any evacuation of one of the houses or apartment block. The staff in the adjacent Nursing Home also provides for assistance on evacuation (2 staff) as well as temporary re-accommodation of evacuated residents. This arrangement remains under active review.
• All apartments have been provided with a 2kg Dry Powder fire extinguisher, which are wall-affixed close to exit doors.
• More elaborate and detailed PEEPs now received from BRK Fire and Safety Consultants and being used; All PEEPs now being reviewed and signed off by PIC. PEEPS all reviewed and updated by 13 December 2019.
• PIC to discuss fire safety at residents meeting in January 2020.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• New template for Individual Assessments to be used from January 2020 and all care plans due for renewal will be completed by 28 February 2020.
• PIC will schedule all care plan reviews for completion by 28 February 2020.
• St Mary’s will have care plans on electronic V-Care system by 28 February 2020.
• PIC will audit care plans by 28 February 2020.
• Registered provider will ensure as far as practicably possible that arrangements are in

place to meet identified needs of all residents	
Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Staff all have attended safeguarding training by 6 December 2019.
• Safeguarding policy will be reviewed and updated by 28 February 2020.
• All notifiable incidents will be followed up within 3 working days and HIQA/Safeguarding team notified as required.
• Any allegation of abuse will be fully investigated and follow up actions required for safety of residents will be put in place.
• Staff and PIC shall be vigilant for any signs of abuse that may be occurring and follow up in line with safeguarding policy.

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
Registration Regulation 7(2)(a)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event notify the chief inspector in writing, within 10 days of this occurring, where the person in charge of a designated centre has ceased to be in charge.	Not Compliant	Orange	31/12/2019
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.	Not Compliant	Orange	31/12/2019
Registration	The registered	Not Compliant		31/12/2019

Regulation 7(4)(a)	provider shall give not less than 8 weeks notice in writing to the chief inspector if any of the following is proposed to take place: (a) where the registered provider is a body corporate (whether a natural person, a company or other corporate body), there will be any change to: (i) the ownership of the body (ii) the identity of its director, manager, secretary, chief executive or any similar officer of the body (iii) the name or address of the body and shall supply full and satisfactory information in regard to the matters set out in Schedule 3 in respect of any new person proposed to be registered as a person carrying on the business of the designated centre under (a), (b) or (c).		Orange	
Regulation 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	15/12/2019
Regulation 15(1)	The registered provider shall ensure that the number,	Not Compliant	Red	28/02/2020

	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.			
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	28/02/2020
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.	Not Compliant	Orange	15/12/2019
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	28/02/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a	Not Compliant	Red	28/02/2020

	continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2020
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	31/01/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/01/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/02/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Red	28/02/2020
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management	Not Compliant	Red	28/02/2020

	structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Red	28/02/2020
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	28/02/2020
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	Not Compliant	Red	28/02/2020

	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 concerns regarding the standard of care and support.			
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	28/02/2020
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	28/02/2020
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement	Not Compliant	Orange	31/03/2020

	of purpose.			
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.	Not Compliant	Orange	31/01/2020
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.	Not Compliant	Orange	28/02/2020
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	Not Compliant	Red	28/02/2020

	risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	31/12/2019
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Red	31/12/2019
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	31/12/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	31/01/2020
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Red	15/12/2019
Regulation 28(3)(a)	The registered provider shall	Not Compliant	Red	20/12/2019

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	15/12/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	31/01/2020
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	15/12/2019
Regulation 34(1)(a)	The registered provider shall	Not Compliant	Orange	31/01/2020

	provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Red	28/02/2020
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.	Not Compliant	Orange	31/12/2019
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/01/2020
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints	Not Compliant	Orange	31/12/2019

	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.			
Regulation 05(1)(a)	The person in 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 prior to admission to the designated centre.	Not Compliant	Orange	31/03/2020
Regulation 05(1)(b)	The person in 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.	Not Compliant	Red	28/02/2020
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are	Not Compliant	Red	28/02/2020

	in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2020
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.	Not Compliant	Red	28/02/2020