Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Dublin 10
Type of inspection:	Short Notice Announced
Date of inspection:	09 June 2020
Centre ID:	OSV-0003730
Fieldwork ID:	MON-0029623

About the designated centre

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

The centre is based in Dublin and operated by the Health Service Executive. It consists of two buildings in close proximity to each other, within a hospital campus. Care and support is provided for up to 25 residents over the age of 18, both male and female with a physical, sensory or neurological disability. At the time of inspection there were 19 residents living in the centre. One building consists of two single bedrooms, five shared bedrooms, two bathrooms and two shower rooms, a dining room, day room, physiotherapy gym, multi-sensory room and an adjacent family room. The other building consists of three single bedrooms and four shared bedrooms. All bedrooms in this building are ensuite. In addition, there is a dining room, day room and family room. Support is provided for residents over a 24 hour period by registered nurses and healthcare assistants. The person in charge is supported by two clinical nurse managers with one based in each of the units.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19

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
Tuesday 9 June 2020	11:00hrs to 17:00hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

At the time of this inspection, the centre was emerging from a significant COVID-19 outbreak. One of the centre's two units had been significantly impacted by the pandemic with a considerable number of residents and staff having tested positive for the virus. Each of these residents and staff had recovered at the time of this inspection. The second unit had no confirmed cases.

The pandemic had a significant impact on project timelines linked to a transition plan submitted to the office of the chief inspector. The latter plan was submitted to the office of the chief inspector in September 2018 as part of the centre's registration process. The centre was registered with a condition which required the centre to implement and adhere to the transition plan submitted. The transition plan had provided some assurances to the office of the chief inspector given non compliances identified in the centre. The transition plan outlined proposals for the de-congregation of the centre in line with national policy. A new proposed provider had been identified but had not yet submitted an application to the office of the chief inspector to be registered as the new provider. It was proposed that the new provider would introduce a new governance structure, with a new management and staff team. A number of timelines in the transition plan had not been reached which was directly related to the pandemic.

As part of the inspection, the inspector met briefly with a small number of the residents in one of the units and observed elements of their daily lives on the afternoon of the inspection. These residents were unable to tell the inspector their views of the service but the inspector observed warm interactions between the residents and the staff caring for them.

It was of concern to the inspector that since the pandemic restrictions had been implemented, limited measures had been taken to ensure that individual residents were engaged in meaningful activities in the centre. There were no formal plans in place, for the lifting of current restrictions in line with national guidelines, to increase residents access to meaningful activities in a planned and safe manner in the community. Staff reported that they had spoken with residents about the current health crisis and associated precautions, such as the use of personal protective equipment. This was not always documented. Residents' meetings had not been taking place in the previous three month period but had recommenced with one meeting being held within the previous two week period.

There was some evidence that residents and their family representatives were consulted with, and communicated with, about decisions regarding their care and the running of the centre. However, there had been no formal communication with residents or their families, in more than six months regarding the proposed transitions of residents from their current homes. It was suggested that the new proposed provider would have their own staff team so only a small number of the current team of staff would be transitioning with the residents to their proposed new

homes. The new proposed provider and members of the new staff team had commenced some work with residents but this had been put on hold since the start of the national health emergency at the end of March 2020.

The provider had implemented a contingency plan for the COVID-19 Health emergency. All visiting to both units had been restricted in line with national guidance for the health emergency. Consequently, the inspector did not have an opportunity to speak with the relatives of any of the residents on this inspection but staff reported that they were happy with the care their loved ones were receiving. Residents were supported and encouraged to maintain connections with their families through telephone and video calls.

Capacity and capability

Management systems in place to promote the service provided to be safe, consistent and appropriate to the residents' needs required improvements.

There was a defined management structure in place that identified lines of accountability and responsibility. However, plans for changes in the governance structures, management and staffing arrangements had been proposed and communicated with staff but not finalised. It was proposed that a large number of the current staff and management team would be redeployed. These plans had been put on hold due to the current health emergency and industrial relation issues. There had been limited formal communication regarding this, by the current provider with the staff team in the preceding six month period. in conversation with staff it was evident that there was a level of uncertainty for staff regarding their future role, responsibilities and who they would be accountable to. There was evidence of regular formal and informal contact between the person in charge and the management team. The person in charge was supported by a clinical nurse manager in each of the two units.

An annual review of the quality and safety of care had not been completed by the provider in the preceding period. In addition, unannounced visits to assess the quality and safety of the service had not been completed within the last six months as per the requirements of the regulations. The person in charge and or the clinical nurse manager compiled a quality care matrix on a regular basis which included a review of medication management practices, nursing care plans and personal plans. However this had not been completed in the preceding three month period. A limited number of other audits had been completed. However, the inspector found that some reviews and audits undertaken were not fully effective and had failed to identify issues detected by the inspector on this inspection.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. However, there were five staff vacancies at the time of this inspection. A small number of agency staff were used to cover these absences which meant that there was some consistency of care for the

residents. This was a nurse led service with nursing staff on duty 24/7 to meet the residents' care needs. A medical officer was also available.

Training had been provided to staff to support them in their role and to improve outcomes for residents. However, training records showed that a number of staff were over due to attend some mandatory training and that a small number of staff had yet to complete training for COVID-19. There was a staff training and development policy. A training programme was in place which was coordinated by the provider's education coordinator. There were no volunteers working in the centre at the time of inspection. Staff supervision arrangements were in place. However, it was identified that formal supervision for staff was not being undertaken for some staff in line with the frequency proposed in the provider's policy.

There were complaint management arrangements in place. However, it was identified that a complaint from an external source which had been made known to the office of the chief inspector, in addition to the provider, had not been included on the provider's complaints register or dealt with through the providers complaint process. This meant that there was a potential that other complaints received by the provider might not be appropriately recorded or responded to.

Regulation 15: Staffing

There were five staff vacancies at the time of inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. However, records available on the day of inspection indicated that a number of staff were overdue to attend mandatory training and that a small number of staff had yet to complete training for COVID-19.

Formal supervision for staff was not being undertaken for some staff in line with the frequency proposed in the provider's policy.

Judgment: Not compliant

Regulation 23: Governance and management

An annual review of the quality and safety of care had not been completed by the provider in the preceding period. In addition, unannounced visits to assess the quality and safety of the service had not been completed within the last six months as per the requirements of the regulations. A limited number of other audits had been completed. However, the inspector found that some reviews and audits undertaken were not fully effective and had failed to identify issues detected by the inspector on this inspection. A number of timelines in the transition plan linked to a condition of the centre's current registration had not been reached.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaint from an external source which had been made known to the office of the chief inspector in addition to the provider had not been included on the provider's complaints register or dealt with through the provider's complaint process.

Judgment: Not compliant

Quality and safety

Overall, the residents living in the centre received care and support which was of a good quality and person centred. However, in the preceding three month period a medical model of care had been focused on. As identified on previous inspections, the overall setting was not designed and laid out to meet the aims and objectives of the service, and the number and needs of the residents.

The residents' well-being and welfare was maintained by a good standard of evidence-based care and support. However, improvements were required in relation to personal plan reviews and meeting residents' social care needs. Overall, care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and communication needs and choices. It was noted that residents' personal plans had been updated to ensure that changes to care required as a result of COVID-19 had been recorded. However, it was noted that goals and activities identified for some residents were not specific or measurable. Personal plans had not been reviewed on an annual basis in line with the requirements of the regulations. There was evidence that a multidisciplinary meeting had been held with the involvement of residents and their family representatives where appropriate. None the less, there was limited evidence that the effectiveness of plans in place were reviewed at these meetings or that personal

plans were revised as a result of discussions at the multidisciplinary meeting. The impact of the current precautions and public health messaging on residents, including the potential impact on their psychological well being had not been formally assessed.

Limited measures had been taken to ensure that residents were engaged in meaningful activities in the centre in the preceding three month period. In line with the national pandemic restrictions, access for residents to activities in the community had been restricted. There was minimal documented evidence that residents were engaged in interesting or meaningful activities in the centre. Staff reported that some residents were taken for walks on the grounds of the campus but this was not always recorded. Residents had access to table tennis, board games and arts equipment but there was limited evidence that residents were supported to access these facilities. Social care workers had been employed by the provider through an external agency. However, at the end of March these staff withdrew their service. In addition, a vehicle used by the centre to transport residents for outings was no longer available for use by the centre. There were no formal plans in place, for the lifting of current restrictions to increase residents access to meaningful activities in a planned and safe manner in line with national guidance and public health advice.

Residents' healthcare needs were met in line with their personal plans and assessments. Specific health plans were in place for residents who required same. Nursing staff were on duty 24/7 to meet residents' health care needs. Medical cover was provided by an on-site medical director and four medical officers. Residents also had access to a range of allied health professionals.

There were procedures in place for the prevention and control of infection. However some improvements were required in relation to training for staff. The inspector observed that all areas were clean. However, some areas of the building were old and worn which meant that they could be difficult to effectively clean. For example toilet and bathroom floors. A cleaning schedule was in place which was overseen by the person in charge. Colour coded cleaning equipment was in place. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. The provider had established a local outbreak control team which engaged regularly with the Department of public health and provided guidance and support in the management of the global COVID-19 pandemic. An infection control specialist was available to support the staff team. Specific training in relation to COVID-19, proper use of personal protective equipment and effective hand hygiene had been provided for staff. However, a small number of staff had not yet completed the training. Disposable surgical face masks were being used by all staff whilst in the centre.

The health and safety of residents, visitors and staff were promoted and protected. There were risk management arrangements in place which included a detailed risk management policy, and environmental and individual risk assessments for residents. These outlined appropriate measures in place to control and manage the risks identified, including COVID-19. There were arrangements in place for investigating and learning from incidents and adverse events involving residents.

Incident reviews were completed on a weekly basis by the person in charge with her manager and discussed at a quarterly incident review meeting with other centres on the campus. This promoted opportunities for learning to improve services and prevent incidences.

There were measures in place to keep residents safe and to protect them from harm. At the time of the last inspection, discrepancies had been identified in relation to the financial records held for a sample of residents. This had since been addressed and suitable oversight arrangements had been put in place.

Regulation 13: General welfare and development

Residents were found to have limited access to meaningful and interesting activities in the centre in the preceding three month period.

Judgment: Not compliant

Regulation 17: Premises

As identified on previous inspections, the centre had an institutional feel and concerns remained regarding the suitability and fitness for purpose of the building. The centre was not designed and laid out to meet the aims and objectives of the service, and the number and needs of the residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

Suitable arrangements were in place to promote the safety and health of staff and residents.

Judgment: Compliant

Regulation 27: Protection against infection

Some areas of the building were old and worn which meant that they could be difficult to effectively clean. A small number of staff had not yet completed specific training for COVID-19.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Goals and activities identified for some residents were not specific or measurable. Personal plans had not been reviewed on an annual basis in line with the requirements of the regulations. The impact of the current precautions and public health messaging on residents, including the potential impact on their psychological well being had not been formally assessed.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' healthcare needs were being met.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to keep residents safe and to protect them from harm.

Judgment: Compliant

Regulation 9: Residents' rights

Although there had been some initial consultation with residents and their relatives regarding the proposed transition and de-congregation plans for the centre, there had been limited formal consultation with residents and or their relatives in the preceding six month period.

Judgment: Substantially 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	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cherry Orchard Hospital OSV-0003730

Inspection ID: MON-0029623

Date of inspection: 09/06/2020

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:
There are five vacant permanent posts. These posts are currently covered by a small number of regular HCA agency staff. Vacant nursing positions are covered by overtime by regular nursing staff in the unit. This is to ensure continuity of care and provision of quality and safe care to residents.

The new provider applied for their registration on 04/09/2020. They would introduce a new governance structure, with a new management and staff team. They have established an oversight group consisting of their CEO, Quality Assurance Manager, and Director of Person Support Services who have engaged with residents, their families, and advocates and staff to determine needs in the designated centre.

The new provider has recruited 16 new staff members and has completed their induction process. While waiting for their registration, these staff are currently hired as agency staff to support the residents and existing staff in Lisbri unit ensuring the social care model is being delivered. Three support workers and a team leader are rostered daily from 07/09/2020.

Current staffing levels in Lisbri are as follows:

07.45-16.45 3 RGN's and 4 HCA's
16.45-20.00 2 RGN's and 3 HCA's
20.00-08.00 1 RGN's and 1 HCA's + 1HCA (20.00-24.00)
8.00 – 20.00 3 Support workers + 1 Team Leader (8.00 – 18:00)

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training resumed on campus on 18/06/2020 following the development of a protocol by the Education Officer on 'mandatory training during a COVID -19 pandemic'. This protocol supports instructors, staff, and ultimately residents by allowing the safe provision of education whilst being guided by National Policies. Mandatory training continued throughout the summer months addressing gaps in training that developed throughout the COVID outbreak.

Two extra sessions were completed with the Infection Control Lead Nurse to provide training to Elm and Lisbri Staff on 04/08/2020 and 05/08/2020 to achieve 100% compliance in Infection Control.

The fire officer provided an extra training session on 29/07/2020. 100% compliance in fire training.

All mandatory training was assessed to reduce the length of time required for face to face training to promote optimal safety for all. Staff has to complete theory modules in an on-line training platform and practical sessions will be delivered by instructors via 60 to 90-minute classroom sessions.

Manual handling training has resumed. We are 86% compliant with two members of staff outstanding. They are both rostered on the next Manual Handling training on 08/10/2020 where we will then be 100% compliant.

For Basic Life Support training, staff will have access to online training with the Irish Heart Foundation (theory) from the week of 14/09/2020. The practical sessions will run for an hour and are due to start on 01/10/2020. This approach promotes staff safety and increases the number of sessions we can facilitate. 100% compliance in this training is expected by end of November 2020.

The HSE would like to clarify an error in our records relating to safeguarding training as presented to the HIQA inspector on the 9th of June. The education officer had dated all staffs' safeguarding training records as requiring renewal every 2 years; therefore it appeared that many staff were outside of compliance with safeguarding training. In actual fact following email consultation with the National Safeguarding Office, it has been confirmed that Safeguarding training is actually required every three years. Consequently, all staff members in both Elm and Lisbri are 100% compliant with this training requirement.

A Safeguarding training programme was designed for HSELand and is now available for staff access since July 2020. Staff will be scheduled for participation in this training to ensure continued compliance with training requirements.

The formal supervision of staff occurs every three months. This resumed in May 2020

following a temporary pause during the COVID outbreak. All staff, including the PIC, received formal supervision in May/June 2020. Staff are scheduled for their next supervision for August/September 2020.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Annual Review and the Six-Monthly Unannounced Visit reports were completed and submitted to HIQA on 17/06/2020. The provider nominee has recommenced monthly unannounced visits. One was completed for Lisbri Unit on 23/06/2020 and for Elm on 01/07/2020. If the provider nominee is unable to complete these visits, the PPIM will complete same.

An Assistant Director of Nursing has been identified to lead on the clinical audit process across campus. This individual will be responsible for reviewing the schedule of audits, ensuring their timely completion, communicating across services, and monitoring quality improvement plans to preserve robust standards. All information and actions will be communicated to the quality and safety committee, the monthly nursing admin, and the monthly CNM meetings.

Further information on appropriate governance and management structures will be provided based on the outcome of the proposed organisational transition plan submitted to HIQA on the 14th of July 2020.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints procedure in the units is adhered to at all times. All complaints are registered, followed up, and reviewed monthly. There is also a quarterly Complaints Audit in place completed by the Assistant Director of Nursing.

All Residents, their families, and representatives are informed of the process of making a complaint. Information and leaflets are available within the units. As a reminder, the Complaints procedure is listed as one of the items on the agenda for 26/09/2020 Resident's meeting.

The complaints procedure is due to be reviewed or revised by December 2020.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
While the campus continues to deal with the on-going response to COVID, two additional HCA's were employed on 06/07/2020 to work with each resident to ensure they are engaging in their meaningful and interesting activities. One staff member is a core member of the Cherry Orchard Activity group who has been working on structured activities with our residents. A weekly activities log is completed reflecting the choices of residents following consultation with them. CNM1 reviews these activities and facilitates the support required to run them.

Art therapy is available to residents twice a week since 02/07/2020.

Individual MDT meetings resumed on 15/07/2020. Both medical and social care needs are reviewed at this meeting, including specific and measurable personal goals. Residents' families and/or representatives are invited to attend and take part. Action plans from the meeting are followed up and coordinated by support workers ensuring the needs, goals, and wishes of the particular resident are met.

Agency support workers started working with residents on 07/09/2020. They review resident's goals and incorporate them in the weekly activities log. They also identify meaningful and interesting activities; indoor and outdoor, suitable for residents.

St Margaret's Discovery workers will commence on the introduction of the SSDL process in the unit on 18/09/2020. This introduction will be on a phased basis to ensure service users are not overwhelmed by the process. This process will proceed regardless of provider in line with funding secured from GENIO to facilitate this process.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The design and layout of the premises does not meet all resident's needs. However, it is intended to close Lisbri as per condition of registration by the 31/10/2021. In the meantime, the HSE will continue to explore all options to improve current suitability of

premises. The HSE will work closely with St Margaret's as part of SSDL process to identify and implement improvements on a continuous basis.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The HSE continues to employ full-time household cleaning staff to maintain the cleanliness of both units. To ensure standards are of an appropriate level a series of unannounced inspections by the household manager and inspection control by a clinical nurse specialist was introduced in March 2020.

Staff members in both Elm and Lisbri completed Hand Hygiene, Donning and Doffing of PPE training modules on HSELand. 100% compliance in their training was achieved on 05/08/2020.

Training resumed on campus on 18/06/2020 following the development of a protocol by the education officer on mandatory training during a COVID -19 pandemic. This protocol will support instructors, staff, and ultimately residents by allowing for the provision of an education safely whilst being guided by National Policies. Two extra sessions were booked with the Infection Control Lead Nurse to provide Infection Control training to Elm and Lisbri Staff on August 4th and 5th 2020. 100% compliance.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Individual MDT meetings have recommenced since July 2020. These meetings take place twice a year. Each resident's medical and social care needs are reviewed and personal goals and plans are generated during the meeting.

With agency support workers now on board, the structure of MDT meetings was reviewed. Each resident's key worker (staff nurse or HCA) and a support worker will complete the person-centered plan (PCP) for each resident. Support workers will hold a monthly PCP review meetings of each resident's goals. The review will include updates, proposed changes and its rationale, and name of person responsible for pursuing objectives in the plan with agreed timelines. This change will commence from

15/09/2020.

A yearly survey is conducted by our Allied Healthcare Professionals (AHPs). The Resident's survey was completed in August 2020. The Family survey is underway. AHPs are currently waiting for the return of some questionnaires from residents' family. These surveys included questions about the services they received during the pandemic. Feedback from the residents about the care they received during the outbreak is very positive.

The medical officer engages with residents on a regular basis. His role with the residents is not task orientated but it is more holistic. He visits the unit at least 5 days each week. He engages regularly with the residents and continued to do so during the outbreak on Lisbri and also since the closure of the outbreak. He has discussed the impact of the Covid outbreak with individual residents as well as the impact that the restrictions were having on their quality of life. While most were finding that the restrictions were having a significant impact on their quality of life and were looking forward to the easing of restrictions, none were found to be impacted to the extent that, in the opinion of the experienced medical officer, they required referral to specialist psychological or psychiatric services.

Agency support workers will work with individual residents and complete the 'Reflection and Story Telling' project. Each resident will be encouraged and supported to tell their story about their experience during the pandemic (including the lockdown), how they feel about it, how it affects their lives, and what they can do or what our staff can do to help them should this happen again. This project will start from the week of 14/09/2020.

For the Residents Monthly meeting on 26/09/2020, items on the agenda include the Impact of the lockdown in their lives, their suggestions to help alleviate these impacts on their day to day lives, and how they can support each other, as a group, during this difficult time. All residents and their families are encouraged to attend.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: HSE has written on 06/07/200 to residents and families to assure them that de-congregation plans for Lisbri will re-commence post COVID emergency response period. The HSE has requested consent from each resident who was identified for de-congregation for assessment by the third party to commence the discovery process. The introduction of the new provider staff to the residents was completed. Assessments commenced on the 15/07/2020.

There were 3 residents (identified for de-congregation) were identified with a lack of capacity to make decisions. A referral for each resident was made to National Advocacy Service and they were allocated with their own individual advocate subsequently. With

their family and advocate, they have consented for assessment.

Residents want to be updated on the transition to the new provider and for de-congregation. It is decided to include General Updates on the Transition / de-congregation on the agenda for monthly Residents' meeting.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/09/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/08/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Not Compliant	Orange	31/08/2020

	appropriate training, including 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.	Substantially Compliant	Yellow	31/08/2020
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/10/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2020
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	Not Compliant	Orange	31/01/2021

	accordance with standards.			
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 concerns regarding the standard of care and support.	Not Compliant	Yellow	31/01/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/09/2020
Regulation 34(2)(f)	The registered provider shall	Not Compliant	Orange	30/09/2020

	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.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/09/2020
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/11/2020
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her	Substantially Compliant	Yellow	31/10/2020

	disability is consulted and participates in the organisation of the designated centre.			