Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Pampuri Lawns
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	05 December 2018
Centre ID:	OSV-0005645
Fieldwork ID:	MON-0023411

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 in in West Dublin. It is operated by St John of God and provides services to 11 residents who have varied support requirements over the age of 18. The designated centre consists of two houses. The first house is home to five residents and consisted of five bedrooms, kitchen/dining and living room, a utility room, visitor room, an office, and two bathrooms. The second house is home to six residents and consisted of a five bedrooms, an office, living room, kitchen, utility room, and two bathrooms. In addition, there is a self contained apartment which is home to one resident and consisted of a kitchen/sitting room, bathroom and bedroom. The two units are located close to local shops and transport links. The centre is staffed by a person in charge, social care workers and care assistants.

The following information outlines some additional data on this centre.

Current registration end date:	21/01/2021
Number of residents on the date of inspection:	10

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
05 December 2018	10:30hrs to 19:00hrs	Sinead Whitely	Lead
05 December 2018	10:30hrs to 19:00hrs	Conan O'Hara	Support

Views of people who use the service

The inspectors had the opportunity to meet and spend time with 10 residents during the inspection. Some residents communicated their thoughts and opinions verbally, others used non verbal methods to communicate. One resident was not in the designated centre on the day of the inspection.

Residents appeared relaxed and comfortable in their home, and had personalised their own space. Positive interactions were observed between residents on the day of inspection. Staff providing support for residents were warm, friendly and respectful and appeared knowledgeable about the resident's individual preferences. Inspectors observed some residents partaking in their different preferred daily activities on the day of inspection.

One resident spoke with an inspector and expressed that they were not happy living in the house at present. They further communicated that this was due to regular sleep disturbance caused by noise. No other complaints were communicated with the inspectors on the day of inspection. One other resident expressed they were happy living in the centre and spoke positively about the staff working with them.

Capacity and capability

Overall, from speaking with residents, staff and management, inspectors were not assured that there were effective management systems in place to deliver a safe service. Improvements were required in staffing, training, and the effective management of the service. Due to the significant levels of non compliance evidenced on this inspection the provider will be issued with a Notice of Proposed Decision to Cancel the renewal of registration for this centre.

At the time of inspection, there was a clearly defined management structure in place in the designated centre. However, considering the cumulative non compliances identified on inspection, inspectors were not assured that the governance and management systems in place ensured a safe and effective service. The management systems in place were not effective in addressing high risk issues highlighted through internal audits in a timely manner. There were regular audit systems in place, with six monthly audits carried out by a person participating in management (PPIM). However these audits did were not driving improvements in the centre at times. The placement of one resident in this designated centre was highlighted by PPIMs as a barrier to addressing some issues identified on the service quality improvement plan. The person in charge maintained a clear record of any outstanding maintenance issues and submitted these to the provider and the service

maintenance department. However, the provider was failing to address these issues identified in a timely manner.

The inspectors reviewed a sample of the planned and actual roster and found that the number and skill mix of staff was not appropriate to the number and assessed needs of the residents. For example, on the day of inspection inspectors observed that there was insufficient staffing to effectively implement risk management controls while supporting residents in the designated centre. In addition, there was a reliance on relief and agency staff which did not always ensure that residents received continuity of care and support. Following inspection, the inspectors requested assurances from the provider regarding the staffing levels in the designated centre.

The inspectors reviewed staff training records and found that not all staff had received appropriate training to support residents with specific identified health care needs. This meant that not all staff had been suitably trained to ensure that the residents' needs were appropriately and continuously met. Some staff had received training in the management of one specific healthcare need, however this training did not appear to be informing best practice when supporting the resident with this healthcare need.

The inspectors reviewed a sample of incidents and accidents and found that they were appropriately recorded and notified to the Office of the Chief Inspector as required by the regulations.

There was a complaints process in place with a designated person nominated to deal with complaints. One resident communicated a complaint with an inspector on the day of inspection. Staff and management were aware of this complaint, however a record of the investigation, measures and outcomes of this complaint was not adequately recorded. Furthermore, the resident had not been adequately informed or updated regarding the actions taken. This complaint had been recorded as closed, despite evidence that the resident continued to raise the issue.

There was an up-to-date statement of purpose containing information set out in Schedule 1. However, the care being provided was not in line with residents' needs, particularly in relation to healthcare needs. The exclusion criteria outlined for admission to the designated centre was not in line with residents living there. Furthermore, this version did not identify all conditions attached to the registration of the designated centre.

Regulation 15: Staffing

The number and skill mix was not appropriate to the number and assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Not all staff had received appropriate training to support residents with identified health care needs. These meant that staff had not been suitably trained to ensure that the residents' needs were appropriately and continuously met.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place in the designated centre. There were regular audit systems in place. However, these were not being utilised to improve the quality and safety of the service as the management systems in place were not effective in addressing high risk issues highlighted through internal audits in a timely manner.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was an up-to-date statement of purpose containing all information set out in Schedule 1. However, the care being provided was not reflective or in line with residents' needs, particularly in relation to exclusion criteria for admission to the designated centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

Incidents and accidents were appropriately notified to the Office of the Chief Inspector as required by the Regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints process in place with a designated person nominated to deal with complaints. One resident communicated a complaint with an inspector on the day of inspection. Staff and management were aware of this complaint, however a record of the investigation, measures and outcome of this complaint was not adequately recorded. The resident had not been adequately informed or updated regarding the actions taken.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that the quality and safety of the service received by residents required significant improvements in relation to premises, fire safety, risk management, assessments and personal plans, and health care.

On the day of inspection, the inspectors reviewed a sample of residents' files and found that there were up-to-date in the assessment of needs. However, the assessment of need did not, in all cases, inform the care plans in place for each resident. This meant staff were not appropriately guided and supported to meet the residents' needs. For example, one resident's healthcare assessment identified staff working with them should have appropriate training to support them with a particular healthcare need. This was not implemented and staff had not received this training. An assessment for the suitability of one resident's environment was out-of-date, despite the need for review arising on several occasions.

In relation to healthcare, the inspectors found that significant improvements were required to ensure that all residents were supported to manage their healthcare needs and enjoy best possible health. Residents with identified healthcare needs were not supported with access to nursing support as appropriate and, as reported above and staff were not appropriately trained in the management of identified health care needs. In addition, there was inadequate oversight of the fluid output of a resident who had a specific healthcare need which increased the risk of complications associated with this healthcare need. Allied healthcare professionals were available to residents. These included occupational therapy, physiotherapy, speech and language therapy and dietetics. However, appropriate referrals to allied healthcare professionals were not always being made by staff supporting the residents. One resident had not been reviewed by a physiotherapist for 21 months, despite the need for review arising on several occasions. Following inspection, the inspectors requested assurances from the provider regarding meeting the assessed healthcare needs of the residents.

The centre consisted of two houses in West Dublin. At the previous inspection, it

was identified that one house required significant improvements to ensure that it was maintained to an appropriate standard and had sufficient communal space to meet the needs of the residents living there. The inspectors completed a walk-through of the centre and found that this house still required substantial work. Inspectors observed areas of the house which were not maintained to an appropriate standard, with staining on paintwork, staining on carpets, broken blinds and markings on radiators, doors and skirting boards. One bedroom was not suitable to meet the assessed needs of a resident. Recommendations were outlined for this resident in an occupational therapy report. Not all of these recommendations had been implemented by the provider. While the second house was maintained to higher standard, improvements were also required in paintwork and worn furniture. In addition, there was a malodour in the second house which the maintenance team were in the process of investigating.

There were arrangements in place for the management of risk. However, this required improvement as not all risks were appropriately identified including fire safety. In addition, inspectors observed the control measures for identified risks not being implemented. For example, a resident who required supervision at meal times was observed to be unsupervised during a meal time. Prevention measures for residents at risk of falling were not appropriately reviewed and at times not implemented. One resident had no falls risk assessment in place, despite having a history of falling. As previously outlined, the providers failure to implement environmental changes recommended by occupational therapy increased one resident's risk of falling.

There were systems in place for fire safety management, however the arrangements in place for the containment of fire was inadequate. The centre had suitable fire equipment in place including a fire alarm, emergency lighting and fire extinguishers which were appropriately serviced. However, on the walk through of the centre, the inspectors observed one fire door being wedged open, a number of self closure mechanisms being compromised and a number of fire doors not closing completely. This meant in the event of a fire the doors would not close and contain the spread of fire and smoke. This was identified at the previous inspection. Following inspection, the inspectors requested further assurances from the provider regarding arrangements for the containment of fire.

Centre records demonstrated the fire drills were carried out regularly. However, night time drills did not demonstrate that all residents could be safely evacuated in a timely manner at night. It was not evident how the provider planned to address this issue. Personal Emergency Evacuation Plans (PEEPs) were in place for each resident however not all PEEPs accurately reflected the needs and supports of residents in the event of fire. Also, inspectors found that a response taken by the provider to an emergency situation for one resident, did not ensure appropriate fire safety arrangements were put in place at all times. This example has been omitted from the report to protect the anonymity of the resident concerned but was discussed in the feedback meeting. This resident was not in the designated centre on the day of inspection.

The registered provider had failed to protect all resident from all forms of abuse.

This was particularly in relation to neglect secondary to issues regarding the quality and safety of the service being received by the residents. Concerns in relation to fire safety, staffing and healthcare were placing residents at significant risk. Furthermore, one staff member had not received up-to-date training in relation to safeguarding residents and the prevention, detection and response to abuse. The inspectors acknowledges there was a plan in place to ensure all staff receive up-to-date mandatory training and post inspection it had been achieved. The inspectors also acknowledge staff appeared to have good knowledge of safeguarding measures when spoken with.

Regulation 17: Premises

Inspectors observed areas of the house were not maintained to an appropriate standard, with staining on paintwork, staining on carpets, broken blinds and markings on radiators, doors and skirting boards. One bedroom was not suitable to meet the assessed needs of a resident.

Judgment: Not compliant

Regulation 26: Risk management procedures

Not all risks were appropriately managed or reviewed as outlined in the body of the report.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors identified areas of concern in relation to fire precaution. Fire drills were carried out regularly, however, night time drills did not demonstrate that all residents could be safely evacuated in a timely manner at night. Personal Emergency Evacuation Plans (PEEPs) were in place for each resident, however not all PEEPs accurately reflected the needs and supports of residents in the event of fire. Also, inspectors found that a response taken by the provider to an emergency situation did not take measures to ensure appropriate fire safety arrangements were put in place.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were up-to-date assessment of needs in place. However, the assessment of needs did not, in all cases, inform the care plans in place for each resident. This meant staff were not appropriately guided and supported to meet the residents' needs.

Judgment: Not compliant

Regulation 6: Health care

Significant improvements were required to ensure the all residents were supported to manage their healthcare needs and enjoy their best possible health. Residents with identified healthcare needs were not supported with access to nursing support as appropriate and, as reported above, staff were not appropriately trained in the management of identified healthcare needs.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had failed to protect all residents from all forms of abuse, particularly abuse secondary to neglect. One staff member had not received up-to-date training in relation to safeguarding residents and the prevention, detection and response to abuse.

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
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Pampuri Lawns OSV-0005645

Inspection ID: MON-0023411

Date of inspection: 05/12/2018

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Where hospital/GP appointments are scheduled / planned for residents, the roster is adjusted to facilitate either morning or afternoon appointments to ensure staffing levels are maintained. This is monitored by the Person in Charge in line with local procedure. • Where it was identified that the needs of a resident were unable to be met within the current environment in the designated centre and in line with the Statement of Purpose, support was sought through the public health nurse and community nursing team. Where they were unable to assist, this was escalated to the HSE at monthly case reviews. Application for the Fair Deal Scheme has been made successfully on 3 occasions for the Resident to transition to the appropriate services and environment that he requires to meet his assessed needs. • In addition, risk assessments which were available on the day, were completed, identified on the Risk Register and escalated to the Board. • The resident and the family of the person concerned are now being supported directly by the HSE to complete a transition to an appropriate setting. An assessment of need has been completed by a number of Health Care Providers to support this resident to transition to appropriate accommodation that meets the his needs. The HSE have been advised that the resident needs to transition to a Nursing Home environment by 31st January 2019. • A full review of the rosters in this designated centre for the last quarter indicates that 81% of shifts were covered by permanent staff. Where relief and agency staff are necessary due to leave cover, familiar relief and agency staff are requested.	
Regulation 16: Training and staff	Not Compliant

development	
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The staff training schedule was audited on the 16th January 2019. All staff are currently up to date on mandatory training. • All staff have completed a training module in Diabetes through the Diabetes Ireland website. Additional formal training in Diabetes has also been scheduled for the 19th February 2019. • All staff completed Dementia Training by 23/01/2019. • Additional catheter care training was provided to staff on the 22nd January 2019 to a level relevant and appropriate to the grade and qualification of staff. • One staff who required refresher training in Safeguarding of Vulnerable Adults completed same on 13/01/2019.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Appointments are planned to ensure there is an effective staffing level at all times, this involves the roster being adjusted to facilitate either morning or afternoon appointments and ensuring staffing levels are maintained. This is monitored by the Person in Charge in line with local procedure. • One resident is being supported to move to an alternative service provider as the Designated Centre does not meet his assessed needs. The resident and their family are being supported directly by the HSE and have been since November 2017 for to complete transitioning to an appropriate setting. • A peer audit schedule is in place and audits of the Designated Centre are completed regularly. Unannounced visits on behalf of the Registered Provider are conducted bi-annually as required under legislation. • Actions highlighted from these audits are included in the Quality Enhancement Plan which is overseen by the Person in Charge and line management. The Plan is reviewed monthly. • There was an audit completed on behalf of the Registered Provider on the 21st January 2019. The actions identified along with the actions outlined in this Compliance Plan have been included in the Quality Enhancement Plan.	
Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • The Statement of Purpose will be reviewed and updated to reflect the service provided in the designated centre including additional information in relation to the exclusion criteria and all the conditions attached to the registration of the designated centre.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The resident that made a complaint on the day of the inspection had been met with previously to log this concern and this was addressed at the time. • The Person in Charge will review the documentation of the previous complaint to ensure all interventions were evidenced and filed. • The Person in Charge met with the resident on 21/01/2019 to reactivate the complaint and is supporting the resident with their issues. The resident has planned ongoing meetings with the Person in Charge and Complaints Officer until the complaint is resolved.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • One resident is being supported to move to an alternative provider as the environment within Designated Centre does not meet their needs. All repairs required are scheduled for completion. This includes: • Magnetic door closers were fitted on the required fire doors on 24/01/19 to address the door being wedged open and to ensure the doors close appropriately. • Malodour being technically investigated and new flooring being installed. • Paintwork on doors, skirting boards and communal areas will be completed by 31/01/2019. • Carpet to be replaced on 30/01/19. • Issues with blinds in both houses being addressed. • The couch is being reupholstered.	

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A full review and audit of risk management processes will be completed by the Person in Charge in conjunction with the Residential Coordinator in line with the new policies.
• Risk assessments have been developed for anyone who may not fully participate in fire drills. This was completed in conjunction with the local fire services, the Clinical Risk & Safety Manager and the Occupational Health and Safety Advisor.
• Falls risk assessment has been updated and referral has been made to Physiotherapy for support.
• Staffing levels were reviewed to ensure there were safe and effective levels of support available to residents.
• One residents eating, drinking and swallowing plan was reviewed by the Speech and Language Therapist in relation to providing detail on the correct level of supervision to be provided during mealtimes.
• Staff have been provided with additional relevant training to ensure they are knowledgeable on how best to support residents with their healthcare needs to reduce any potential risk to their health.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Magnetic closers have been installed on the necessary doors to facilitate same being be left open for resident with mobility issues if they so wish when the alarm has not activated.
• Doors that do not require magnetic closers have been reviewed and are due to be re-gassed to ensure they are closing properly.
• Accessible training in Fire Drills has been conducted with residents who are hesitant to take part in deep sleep fire drills.
• Risk assessments have also been developed in relation to this in conjunction with the Person in Charge, Residential Coordinator, Clinical Safety Manager and Occupational Health and Safety Advisor.
• The Person in Charge has linked in with the local fire services in relation to residents who may not fully participate in a fire drill. In addition the fire station services have endeavoured to visit the designated centre and have also provided us with estimated time of arrivals in peak times of the day versus night time.
• Where applicable residents Positive Behaviour Support Plans are being reviewed. The review will include exploring alternative ways to encourage resident's participation in fire drills.
• Additional fire drills since the inspection were conducted on the 11/12/2018 and

24/01/2019.
• All Personal Emergency Evacuation Plans were updated after the drills and provide additional information on how to support residents who do not fully participate.

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:
• All residents' personal plans are updated annually or more frequently as required, this includes assessments on health and social care needs. These will be updated in line with review dates and reviewed by the Person in Charge.
• All staff are familiar with care plans in place for all residents and ensuring that actions within care plans are being adhered to.
• Where additional supports are required for residents in line with their changing needs, efforts to acquire such supports in the community will be clearly evidenced in the personal plan.
• Where it was identified that the needs of a resident were unable to be met within the current environment in the designated centre and in line with the Statement of Purpose support was sought through the public health nurse and community nursing team. Where they were unable to assist, this was escalated to the HSE at monthly case reviews. Application for the Fair Deal Scheme has been made successfully on 3 occasions for the Resident to transition to the appropriate services and environment that he requires to meet his assessed needs.
• In addition, Risk Assessments which were available on the day, were completed, identified on the Risk Register and escalated to the Board.
• The resident and the family of the person concerned are now being supported directly by the HSE to complete a transition to an appropriate setting.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Health Assessments and corresponding care plans are updated annually or more frequently as required to ensure they are being used effectively.
• The Person in Charge audits the Personal Plans annually to ensure this work is complete.
• All staff are familiar with care plans in place for all residents and ensuring that actions within care plans are being adhered to.
• Where additional supports are required for residents in line with their changing needs,

efforts to acquire such supports in the community will be clearly evidenced in the personal plan.
• Where it was identified that the needs of a resident were unable to be met within the current environment in the designated centre and in line with the Statement of Purpose support was sought through the public health nurse and community nursing team. Where they were unable to assist, this was escalated to the HSE at monthly case reviews. Application for the Fair Deal Scheme has been made successfully on 3 occasions for the Resident to transition to the appropriate services and environment that he requires to meet his assessed needs.
• In addition, Risk Assessments which were available on the day, were completed, identified on the Risk Register and escalated to the Board.
• The resident and the family of the person concerned are now being supported directly by the HSE to complete a transition to an appropriate setting.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The resident who requires nursing care will be transitioned to an alternative provider to ensure he has access to nursing care.
• One residents eating, drinking and swallowing plan was reviewed by the Speech and Language Therapist. The plan now provides more detail to the appropriate level of supervision that is required for this resident at mealtimes. All staff are familiar with the updated plan.
• One staff that required refresher training in Safeguarding of Vulnerable Adults completed same on 13/12/2018.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/01/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	15/03/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the	Not Compliant	Orange	31/01/2019

	designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/03/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	28/01/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	28/02/2019
Regulation 28(2)(a)	The registered provider shall take adequate precautions	Not Compliant	Orange	28/01/2019

	against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	15/02/2019
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	28/02/2019
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).	Not Compliant	Orange	31/03/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	31/03/2019

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/01/2019
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	13/12/2018