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## The Beeches, OSV-0002342, 08 December 2021

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

## Issued by the Chief Inspector

Name of designated centre:	The Beeches
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Announced
Date of inspection:	08 December 2021
Centre ID:	OSV-0002342
Fieldwork ID:	MON-0027161

## About the designated centre

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

The Beeches is a designated centre operated by St Michael's House. The centre provides care to seven male and female residents who have an intellectual disability with associated complex needs. The centre consists of a large two storey detached eight-bedroomed house located in North Dublin close to local amenities. A service vehicle is also available for residents use. Wheelchair accessibility arrangements are also in place. The centre's facilities include a kitchen, living room(s), bathroom and laundry. Each resident has their own bedroom. There is a communal room on the first floor for residents and families to use. Residents have access to all areas in the house and there is a lift supporting non-ambulant residents to access both floors of the centre. The Beeches is managed by a Person in Charge who is a Clinical Nurse Manager 2, they are supported in their role by a Clinical Nurse Manager 1. Staffing arrangements for the centre include staff nurses, care staff, social care workers, domestic and catering staff. The person in charge is supervised and supported by a person participating in management as part of the provider's governance oversight arrangement for the centre. Each resident is allocated a key worker and co-keyworker that supports residents to engage with and participate in decisions about their own lives and the running of the centre.

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

Number of residents on the date of inspection:	7
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

### **1. Capacity and capability of the service:**

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

### **2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
Wednesday 8 December 2021	09:00hrs to 17:00hrs	Jennifer Deasy	Lead

## What residents told us and what inspectors observed

The inspector had the opportunity to meet with six residents on the day of inspection. Some residents chose to speak with the inspector in more detail about their experiences of living in the designated centre. In line with public health guidance, the inspector wore a face mask and maintained physical distancing at all times during interactions with residents and staff. Several of the residents had completed questionnaires in advance of the inspection and these were made available to the inspector. The inspector used observations, discussions with residents and key staff, resident questionnaires and a review of the documentation to form judgments on the quality of residents' lives in their home. While residents spoke positively about many aspects of life in the designated centre, improvements were required to the living arrangements to ensure that all residents were safeguarded and that their rights were not being restricted.

Residents told the inspector that the house could be "a bit noisy" and that it was hard to live there when other residents were unwell. There were safeguarding plans in place which resulted in restricted access to all parts of the house. Residents expressed through their questionnaires, and in person, to the inspector that they would like more living space. The service manager showed the inspector that plans had recently been drawn up to provide an additional living space to residents. Planning permission or funding for these plans had not yet been approved at the time of inspection.

The inspector saw, on the day of inspection, that this restrictive practice was impacting on residents' access to their home. One resident required sole use of the downstairs living room as prescribed by their support plans. This meant that other residents remained in the kitchen for the entirety of the morning. While there was a small sitting room available upstairs, staff communicated that many residents preferred to be downstairs where staff are available for company and communication.

Residents also communicated that staffing vacancies were impacting on the availability of activities to them in the centre. The inspector saw that some residents had made goals in 2020 which had not yet been achieved. This was attributed by the provider to COVID-19 restrictions and short staffing. However it was not clear that the provider had taken any steps towards progressing these goals when restrictions were eased at various points during the pandemic. The inspector observed that staffing vacancies were impacting on the quality of care for residents. For example, on the morning of inspection, two residents told the inspector that they planned to go shopping. However, their outing was postponed for several hours until a staff member was available to support them. There were no alternative activities offered to the residents in the interim other than those that the residents self-initiated such as knitting and colouring. Access to day services had been restricted for several residents due to COVID-19. Residents told the inspector that

they missed day services and would like to return to them.

One resident and a staff member accompanied the inspector on a walk through of the house. The inspector saw that the house was equipped with facilities to ensure accessibility for all residents including a lift and ceiling tracking hoists. However, improvements were required to the maintenance of the premises. For example, the automatic door closers had recently been moved and bedroom doors had not been repainted once this work was completed. Other areas of the premises required maintenance and this will be further discussed in the quality and safety section of the report.

One resident showed the inspector their room and appeared proud of it. The bedroom was decorated in line with the resident's preferences and displayed their goals as set in 2020 in a visual format. Improvements were required to the measures in place to support residents' rights. For example, one resident stated that they had made a complaint about other residents entering their room. They reported that this was dealt with by staff asking the other resident not to enter their bedroom. The resident stated that they did not have a key to their room as this was not allowed. Another resident stated that they wished to visit a family member who they had not seen for several months. It was unclear why this wish had not been facilitated.

The centre was observed to be clean and tidy. There was a domestic services staff working there on the day of inspection who was available to the centre five days a week. However, there were maintenance issues with the premises which presented an infection prevention and control risk. For example, there was rust on the grab rails beside the toilet which made them difficult to clean and effectively sanitise.

Staff were observed to interact with residents in a respectful and supportive manner. Staff appeared to know residents well and were seen to offer choices and support with daily living tasks such as mealtimes and personal care. Staff were observed to keep residents informed of changes to plans. For example, at midday, when it became clear that there was a delay in the shopping trip, staff spoke with the residents impacted and asked if they would be ok to have lunch first and to then go shopping.

Overall, the inspector found that while the residents were happy with many aspects of their home, improvements were required to the governance and management, staffing levels and premises in order to ensure that residents were in receipt of a good quality and person-centred service.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being provided.

## Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and to contribute to the decision-making process for the renewal of the centre's registration. The inspector found that enhancements were required to the governance and management of the designated centre to ensure that all services provided were appropriate to residents' needs and were effectively monitored.

At the time of inspection, the person in charge was on long-term leave. The Chief Inspector had been notified as such. The provider had nominated a clinical nurse manager 1 (CNM1) to take the lead in the absence of the person in charge. This CNM1 was supported by a service manager. The person in charge was reported to have dedicated management days in order to ensure oversight of the designated centre. However, due to staffing vacancies, the CNM1 had been unable to avail of these management days. There were no management days allocated to the CNM1 on the roster. This resulted in reduced oversight of the designated centre with significant gaps being identified in staff training and supervision.

Several staff were out-of-date in key training areas such as managing behaviour that is challenging and fire safety. The training matrix which was furnished to the inspector detailed that only approximately half of all mandatory and refresher training was completed. The service manager informed the inspector that this number should be higher as staff had recently completed online training modules however the training matrix had not been updated to reflect this.

Staff supervision, when reviewed, was not carried out as frequently as set out in the provider's policy with some staff having only received two supervisions in 2021. The content of these supervision meetings detailed the significant impact that the staffing vacancies were having on the staff and residents. Staff reported through supervision that the staffing vacancies resulted in reduced social activities for residents and a reported increase in behaviour that was challenging. Another staff reported through supervision that there had been days where they had been unable to take adequate breaks due to low staffing levels.

A planned and actual roster was maintained for the designated centre. A review of the roster demonstrated that staffing levels on a daily basis were in line with the statement of purpose. There were several vacancies in the centre including for two full-time staff nurses, one full-time direct care worker and a chef for 20 hours per week. These vacancies resulted in a high reliance on relief and agency staff to complete the roster.

The provider had completed an annual review and bi-annual reviews of the quality and safety of care of the service as well as their own 32 regulation audit. While these reviews identified areas for improvement, specific targeted actions were not identified. For example, the annual review set out that work was required to address the sitting room area and to make it more comfortable for residents. However, a

time frame for this goal was not set out nor was it allocated to a responsible person.

A review of the local incident log was completed which demonstrated that adverse incidents were notified to the Chief Inspector in accordance with the regulations. There was evidence that appropriate care and support was provided to residents following any adverse incidents.

A complaints policy was available in the centre and had been recently reviewed. An accessible version of this policy was available for residents. The complaints log was reviewed and showed that where residents had made complaints, that these were responded to promptly and to the satisfaction of the residents.

There was one resident who the inspector did not have the opportunity to meet on the day of inspection as they were temporarily absent from the designated centre. The service manager provided evidence of the ongoing contact between the provider and the person taking responsibility for the care, support and welfare of the resident to ensure that their needs were being met and that care was being provided in accordance with the resident's assessed needs.

## Regulation 15: Staffing

There were several vacancies in the designated centre on the day of inspection, including:

- two whole time equivalent staff nurses
- one whole time equivalent direct support worker
- one chef for 20 hours per week

A planned and actual roster was maintained which detailed a high reliance on relief and agency staff in order to complete the roster. Even with a full roster, staff and residents reported that they felt that they were short-staffed and that this impacted on the availability of activities for residents. Staffing vacancies were also reported by staff to contribute to an increase of behaviour that is challenging in the centre.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

A review of the training matrix identified that approximately half of staff training needs were unmet. The service manager informed the inspector that this was not an accurate reflection of the levels of staff training as several staff had recently completed online training. The training matrix did not reflect this recently completed training. Unmet training needs as set out in the training matrix included:

- fire safety - 43% of staff required this
- managing behaviour that is challenging - 64% of staff required this
- COVID19 - 36% of staff required this
- Children First - 64% of staff required this
- Feeding, Eating, Drinking and Swallowing (FEDS) - 92% of staff required this
- Safeguarding - 14% of staff required this

Most staff had accessed two staff supervisions during the past 12 months. The frequency of these supervisions were not in line with the provider's policy.

Judgment: Substantially compliant

### Regulation 23: Governance and management

The governance and management arrangements required enhancement to ensure effective oversight of the day to day running of the centre. A clinical nurse manager 1 (CNM1) had been nominated as the responsible person for the centre in the person in charge's absence. However, the CNM1 did not have allocated management days. This led to poor oversight of staff training and supervision. Many residents in the centre had complex assessed needs which required support from specifically trained staff.

Additionally, it was not clear that there was sufficient oversight of the measures in place to involve residents in the running of the centre, to capture their choices and wishes and to ensure progression of resident goals.

Improvements were also required to the oversight of goal progression through the provider led audits to ensure that areas for improvement were identified with specific, measurable, achievable and time-bound goals.

While a review of the roster demonstrated that staffing allocations were in line with the statement of purpose, due to staff vacancies, there was a high reliance on relief and agency staff to complete the roster. Staff and residents reported that they were often short-staffed and this impacted on availability of resident activities and an increase in behaviour that challenges.

Judgment: Not compliant

### Regulation 31: Notification of incidents

A review of adverse incidents in the designated centre demonstrated that all incidents were notified to the chief inspector in line with the regulations.

Judgment: Compliant

### Regulation 34: Complaints procedure

A complaints policy was available in the centre and had been recently reviewed. Where complaints had been made, the provider had investigated these promptly. Residents spoken with stated they were happy with the outcome of their complaint and with how it was managed by the provider.

Judgment: Compliant

### Quality and safety

This section of the report details the quality and safety of the service and how safe it was for the residents who lived in the designated centre. Overall, the inspector found that while the house was clean and was equipped to meet residents' needs, improvements were required to the oversight of the running of the centre to ensure that residents were in receipt of a quality and person-centred service.

The house was observed to be generally clean and tidy. The provider had taken measures to protect residents from acquiring a health-care associated infection. Temperature checks were taken at the door and a log of visitor details was maintained to support contact tracing. Staff were observed wearing face masks and socially distancing where practicable. There was a recently updated COVID-19 house plan which detailed procedures to be followed in the event of a suspected or confirmed case of COVID-19. Staff were aware of where to find this plan and of the procedures to be followed in this instance. Staff were also observed to support residents to maintain good hand hygiene practices before meals and medications.

There were several premises related issues which presented infection prevention and control risks. The provider was aware of some these risks and had identified them through their own checklists and audits. For example, there was rust on the grab handles in bathrooms which made them difficult to effectively sanitise. A couch in the upstairs sitting room was also peeling and was covered with a wipeable tablecloth on the day of inspection. A maintenance request had been logged in November 2021 to address these risks.

The premises required maintenance and upkeep in several areas. Painting was required on doors and ceilings. A resident had also requested to have their bedroom painted in June and a request was logged with maintenance however this had not been actioned at the time of inspection.

A review of resident files detailed that most residents had an up-to-date assessment

of need carried out by a relevant health care professional. There was no recently reviewed assessment of need in place for one resident who had been temporarily absent from the designated centre since the start of the pandemic. However, the service manager provided evidence of the information that had been given to the person taking responsibility for the care, support and well-being of that resident. There was also documented evidence of the ongoing support being provided to that resident by the provider while they were temporarily absent from the centre. For example, the provider was ensuring that the resident's carer was being kept informed of all health care appointments and care meetings had been held between the provider and the carer to ensure care needs were being met.

Where residents had assessed needs, these were supported by comprehensive support plans which detailed access to a variety of allied health care professionals including General Practitioners, Mental Health teams, physiotherapy and speech and language therapy. Residents had a recently completed personal plan entitled "all about me" which detailed their assessed needs and required supports. These plans were completed in consultation with the individual residents.

The majority of staff required updated training in managing behaviour that is challenging. Positive behaviour support plans were in place for those residents who required them. Behaviour support plans were further supported by mental health plans where required. Improvement was required to the mental health plans to ensure that specific guidance was provided to staff in supporting residents when they were experiencing acute periods of mental health distress. Restrictive practices, where in place, had been reviewed by the provider's positive approaches monitoring group (PAMG). However, it was found that some of the restrictive practices in place were impacting on other residents' rights to freely access all parts of their home. Some residents expressed to the inspector that they would like additional living space downstairs to be made available to them.

A review of the centre's safeguarding folder detailed that there had been a substantial number of peer to peer related safeguarding incidents during the last 12 months. These safeguarding incidents had been investigated and notified in line with the relevant statutory requirements and national guidance. Many of the incidents were attributed to the lack of personal space for residents who required calm, low arousal environments. Additionally, the service manager informed the inspector that the closure of day services had resulted in residents being at home for longer periods of time. This had further increased the general noise and activity level in the house and had resulted in increased safeguarding incidents. The service manager showed the inspector that planning had commenced to propose to change the footprint of the designated centre to afford all residents more personal living space and to reduce the frequency of safeguarding incidents.

Intimate care plans were available for those residents who required support in this area. However, improvements were required to ensure that intimate care plans provided specific guidance to staff on how to ensure that resident's dignity, autonomy and personal preferences were respected during support with intimate care.

Enhancements were required to the activities available to residents in the designated centre and to the measures in place to ensure that residents' rights were upheld. Residents and staff reported that there were often insufficient staff to avail of activities. The inspector observed that there were no alternative activities offered to those residents who were waiting to go shopping when it became apparent that the shopping trip would be delayed. A review of resident files showed that many resident goals, in place since 2020, had not been achieved. Daily reports on resident files also did not demonstrate that residents had sufficient opportunities for occupation, recreation and support to develop personal relationships with the wider community.

Minutes of resident house meetings were not sufficiently detailed to show that residents were being actively consulted with regarding the day to day running of the house. It was not clear that the residents had freedom to exercise their rights and to have control over their daily lives. One resident had made a complaint about other residents accessing their bedroom. While this had been addressed by the provider asking other residents not to enter the bedroom, the resident informed the inspector that they were not allowed to have a key to their room. There was also evidence that some resident goals were not progressed until consultation had taken place with their family members. There was no clear rationale set out for why this consultation needed to occur before progressing these goals.

### Regulation 13: General welfare and development

The provider did not demonstrate that there were sufficient opportunities for residents to engage in activities for occupation and recreation as per their interests, capacities and needs or to develop and maintain personal relationships with the wider community. A review of resident daily reports detailed limited opportunities to access the community.

Resident goals had been unachieved since 2020 and this had been attributed to the pandemic and staffing vacancies. However, there was insufficient evidence to suggest that these were reasonable explanations for the failure of the provider to progress many of the goals as set out by residents.

Judgment: Not compliant

### Regulation 17: Premises

The premises, while of sound construction, required general maintenance and upkeep throughout. Doors required painting throughout the centre and there were several outstanding maintenance issues which present a risk to infection prevention and control. These included rust on bathroom radiators and grab rails, chipped

bathroom tiles, peeling laminate kitchen cabinets and peeling couch in the upstairs sitting room.

Resident bedrooms were observed to be decorated in line with resident preferences. However, there had been a request by one resident to have their bedroom painted in June 2021 and this had not yet been actioned. Provider led audits also identified that some residents would benefit from additional storage in their bedrooms.

Judgment: Substantially compliant

### Regulation 25: Temporary absence, transition and discharge of residents

There were appropriate systems in place to ensure that, where a resident was temporarily absent from the centre, that relevant information was provided to the person taking responsibility for the care support and well-being of that resident.

Judgment: Compliant

### Regulation 27: Protection against infection

The provider had adopted procedures to protect residents from acquiring a health-care associated infection. There were appropriate contingency plans to manage an outbreak of COVID-19. Staff were seen to adhere to standard precautions and to current national health advice. The centre benefited from the allocation of a full-time domestic support worker. However, there were premises issues which presented an infection prevention and control (IPC) risk. These had been identified in the provider's own audits however had not been actioned at the time of inspection. Premises issues which presented an IPC risk included:

- rust on grab rails in bathrooms
- chips in tiles in upstairs bathrooms
- rust on radiator in downstairs bathroom
- peeling laminate cover on kitchen cabinets
- peeling couch in upstairs sitting room

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

Most residents had a recently updated assessment of need completed by an

appropriate health care professional. The assessment of need informed a personal plan which reflected the residents' needs and identified the supports required to meet those needs through comprehensive care plans.

Judgment: Compliant

### Regulation 7: Positive behavioural support

The majority of staff required training in managing behaviour that is challenging. Improvements were also required to ensure that support plans in place for managing behaviour that was challenging and for supporting residents' mental health needs provided clear guidance to staff.

Restrictive practices had been reviewed by the provider's positive approaches to monitoring group (PAMG) and had been notified to the chief inspector accordingly. Some restrictive practices were found to be impacting on the rights of other residents. The provider was in the early stages of proposing changes to the footprint of the building in order to reduce the impact of restrictive practices on all residents.

Judgment: Substantially compliant

### Regulation 8: Protection

A review of safeguarding incidents demonstrated a substantial increase in peer to peer incidents over the past 12 months. This increase was attributed to short staffing, a reduced availability of day service hours and lack of personal space for all residents particularly when some residents were experiencing acute periods of mental illness. Although the provider was aware of ongoing peer compatibility and safeguarding issues and had notified safeguarding incidents to the relevant statutory bodies and investigated accordingly, there was an absence of robust, time-bound, specific plans to address these issues. The inspector was not assured that all residents in the designated centre were protected from abuse at the time of inspection.

Improvements were required to intimate care plans to ensure that resident's dignity, autonomy and personal preferences were supported during the provision of care.

Judgment: Not compliant

### Regulation 9: Residents' rights

Minutes of resident meetings were insufficiently detailed to demonstrate that residents were consulted with and participated in the day to day running of the service. It was not clear that all residents had freedom to exercise choice and control in their daily lives. Residents had limited access to activities for occupation and for links with the wider community. Residents also expressed that their right to privacy and to personal space was impacted by other residents accessing their bedrooms and by the restrictive practices in place which resulted in residents being unable to freely access all communal living areas.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for The Beeches OSV-0002342

Inspection ID: MON-0027161

Date of inspection: 08/12/2021

## 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: <ul style="list-style-type: none"> <li>• Roster review to be carried out 20/1/2022</li> <li>• One Nurse vacancy filled and staff commencing on the 17/1/2021</li> <li>• Chef position filled and staff commencing position by the 17/1/2021</li> <li>• DSW position filled and staff commence on the 13/1/202</li> <li>• Ongoing recruitment to fill other Nurse position 30/4/2022</li> <li>• Residents to commence re-attendance in day services from 26/1 2022</li> </ul>	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: <p>Training Matrix requested in Oct 2021 and had identified training needs which had been completed by staff prior to the Inspection on the 8th Dec, Training records have been reviewed and staff have completed all online staff training ..</p> <ul style="list-style-type: none"> <li>• All staff have completed fire safety training</li> <li>• All staff have completed Covid online training</li> <li>• All staff have completed Childrens first</li> <li>• All staff have completed FED's training</li> <li>• All staff have completed Safeguarding training</li> <li>• Staff supervisions dates have been identified PIC- CNM1 every 8 weeks.</li> <li>• Staff have been identified that require PBSP and these have been scheduled by the training dept for completion by June 2022</li> </ul>	

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Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

- Management hrs identified on the roster from Jan 2022 for CNM1
- Completion of Monthly data reports for review by service manager prior to meetings with PIC- CNM1
- All residents have scheduled Well being review Meetings by March 2022 and from this Goals will be identified for each resident
- Goal tracker in place and evidence recorded of the progression of these Goals based around identified time frames.
- Keyworkers to complete Keyworker checklist Monthly and submit to PIC and service manager to establish progression of Goals.
- Several vacancies have been filed and ongoing recruitment for vacant posts in place.
- Where agency or relief staff are being utilized they are consistent and familiar staff
- All residents to commence re-attendance in Day services. 26/1/2022
- Review of all activities within the DC with evidence of resident involvement in the identification of activities of their choice.
- Review of residents meetings to ensure all residents access this forum in a format that reflects their communication needs, with evidence of their input in the process.
- Provider has engaged with Architect to review options of both internal reconfiguration and additional extension of the DC to provide an enhanced environment for all service users supported.
- Initial drawings submitted for consideration.....
- Update to Draft Drawings to outline specification upon which cost estimate will be based to carry out and complete works.
- Director of Adult Services has escalated issues of compatibility to the HSE- CHO
- DSMAT submitted on the 13/08/2021 and has been discussed at Operational meetings with HSE- CHO most recently the 12/1/2022

Regulation 13: General welfare and development	Not Compliant
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Outline how you are going to come into compliance with Regulation 13: General welfare and development:

- • All residents have scheduled Well being review Meetings by - March 2022 and from this Goals will be identified for each resident for the year ahead.
- Goal tracker in place and evidence recorded of the progression of these Goals based around identified time frames. Where there has been external factors that may affect the

progression of Goals they will be identified on the Goal trackers, and alternative options explored to enable the achievement of the Goal

- Keyworkers to complete Keyworker checklist Monthly and submit to PIC and service manager to establish progression of Goals.
- All residents to commence re-attendance in Day services.
- Review of all activities within the DC with evidence of resident involvement in the identification of activities of their choice.
- Review of residents meetings to ensure all residents access this forum in a format that reflects their communication needs, with evidence of their input in the process

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:

- · Refurbishment of bathroom has been approved and to completed by the- 31/3/2022
- Bathroom radiators; will be replaced
- Grab rails will be replaced during the refurbishment of bathroom
- Replacement of kitchen cabinets: 30/4/2022
- New Couch ordered for upstairs sitting room: Delivery date -24/1/2022
- While additional storage for one resident had been identified by them in previous Provider audit, the resident changed their mind in preference to under bed storage.
- Painting and redecorating has been approved and scheduled for 30/3/2021 Provider has engaged with Architect to review options of both internal reconfiguration and additional extension of the DC to provide an enhanced environment for all service users supported.
- Initial drawings submitted for consideration.....
- Update to Draft Drawings to outline specification upon which cost estimate will be based to carry out and complete works.
- Director of Adult Services has escalated issues of compatibility to the HSE- CHO
- DSMAT submitted on the 13/08/2021 and has been discussed at Operational meetings with HSE- CHO most recently the 12/1/2022

Regulation 27: Protection against infection	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 27: Protection against infection:

- · Refurbishment of bathrooms has been approved and to completed by the- 31/3/2022
- Bathroom radiators; will be replaced
- Grab rails will be replaced during the refurbishment of bathroom

- Replacement of kitchen cabinets: 30/4/2022
- New Couch ordered for upstairs sitting room: Delivery date -24/1/2022
- While additional storage for one resident had been identified by them in previous Provider audit, the resident changed their mind in preference to under bed storage.
- Painting and redecorating has been approved and scheduled for 30/3/2021

Regulation 7: Positive behavioural support	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- Staff have been identified that require PBSP and they have been referred for next available cohort and subsequent Cohorts after this.
- Review of all PBSP underway with respective Psychologist and this will inform staff support planning and development of guidance document supporting residents with their mental health concerns
- Resumption of day services for all residents from the 26/1/2022

Regulation 8: Protection	Not Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection:

- The provider has approved additional staffing to support the residents during periods of poor wellness .
- Residents access to community- day service provision and families has been curtailed over the last year impacting on the wellbeing and mental Health.
- Residents access to the community day services are resuming from the 26/1/2022
- PBS plans are under review by Psychology and will inform support planning for all residents.
- Safeguarding support plan will be reviewed and all aspect of the residents safety considered with time bound plan to ensure complinace
- Activation hrs allocated onto the roster until day service provison has resumed for all residents 26/1/2022
- Review of all intimate care support plans to reflect how the staff will ensure residents choice.
- Provider has engaged with Architect to review options of both internal reconfiguration and additional extension of the DC to provide an enhanced environment for all service users supported.
- Initial drawings submitted for consideration 8/12/2021
- Update to Draft Drawings to outline specification upon which cost estimate will be

based to carry out and complete works.

- Director of Adult Services has escalated issues of compatibility to the HSE- CHO
- DSMAT submitted on the 13/08/2021 and has been discussed at Operational meetings with HSE- CHO most recently the 12/1/2022

Regulation 9: Residents' rights	Not Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

- • Forum of residents meetings has been reviewed with residents to determine the format they feel would best suit.
- Ongoing input from SLT dept in the establishment and development of communication tools specific to each resident communication style.
- Keyworkers to complete Checklist monthly and submit to PIC- Service manager for review
- Review of residents preference regarding activities within the community and keyworker to establish suitability and availability .
- Resident meetings will now include the need for all residents to respect each others personal space.
- Provider has engaged with Architect to review options of both internal reconfiguration and additional extension of the DC to provide an enhanced environment for all service users supported.
- Initial drawings submitted for consideration.....
- Update to Draft Drawings to outline specification upon which cost estimate will be based to carry out and complete works.
- Director of Adult Services has escalated issues of compatibility to the HSE- CHO
- DSMAT submitted on the 13/08/2021 and has been discussed at Operational meetings with HSE- CHO most recently the 12/1/2022

## Section 2:

### Regulations to be complied with

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

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

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/03/2022
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	30/03/2022
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Not Compliant	Orange	30/03/2022

	their wishes.			
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Not Compliant	Orange	30/03/2022
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	30/04/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/04/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2022

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/02/2022
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	30/04/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/04/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2022
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	30/04/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority	Substantially Compliant	Yellow	30/01/2022

	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	30/04/2022
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.	Substantially Compliant	Yellow	14/01/2022
Regulation 23(3)(a)	The registered provider shall ensure that effective	Substantially Compliant	Yellow	28/02/2022

	arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
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	30/04/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/06/2022
Regulation 07(2)	The person in	Substantially	Yellow	30/06/2022

	charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Compliant		
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	28/01/2022
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	30/01/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Red	28/01/2022
Regulation 09(2)(e)	The registered provider shall ensure that each	Substantially Compliant	Yellow	30/01/2022

	resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Red	28/01/2022