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:	Steadfast House Residential Service - Group Home
Name of provider:	Steadfast House Company Limited By Guarantee
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	22 March 2023
Centre ID:	OSV-0001631
Fieldwork ID:	MON-0035008

About the designated centre

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

Steadfast house residential service provides care and support to five female residents on a full time basis. Residents are supported on a individual basis in line with their assessed needs, wishes and preferences. The centre has a staff team consisting of a person in charge, a social care worker, and healthcare assistants. The person in charge is supported in their role by the chief executive officer.
The centre is located within walking distance of a town, and residents can access a range of amenities and activities in the local community. Residents are supported by one to two staff during the day and one staff overnight. Four residents attend day services every day, and one resident is supported with activities in the centre and in the community, as is their preference. The premises is laid out to meet the individual and collective needs of residents in a homely environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 (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 22 March 2023	10:00hrs to 16:15hrs	Caroline Meehan	Lead
Wednesday 22 March 2023	10:00hrs to 14:30hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection completed over one day, and the inspectors had the opportunity to meet with three staff members, the person in charge, and the registered provider representative. All of the residents had gone to day services, and had a planned trip on the evening of the inspection, and therefore the inspectors did not have the opportunity to meet residents on the day of inspection.

The centre provided residential services to five adults on a full-time basis, and was located in a large rural town. Four residents attended day services, and one resident went to some activities in day services each week. A bus was provided in the centre, to support residents to go to day services, or to go on social outings, depending on their own choices.

The centre was laid out to meet the needs of residents, and all parts of the centre were fully accessible. Equipment was provided, where required, to support them with their mobility needs, and overall the centre was well maintained. Additional gardening facilities and an activity cabin were provided to the rear of the property, and residents were reported as enjoying art and craft activities in the cabin. One resident had a goal to develop their gardening skills later in the year.

The centre had recently been redecorated, and residents had been involved in decisions around colour and furnishing choices for their own rooms. The centre was run in a way which respected the privacy and dignity of the residents, and promoted their choice on how they wished to live their day to day life.

Contact between residents and their families was supported, residents visited home or visits from family members were welcomed in the centre. Residents also kept contact with their families through phone calls and they had access to their own phone, or the centre phone. Families were invited by residents and staff to attend an annual review of residents' personal support plans.

From speaking with staff members, it was evident that improvements related to previously identified risks had been embedded in daily practices. Specifically, risks relating safeguarding, behavioural support and incident management had improved overall, and staff were knowledgeable on the measures to report incidents and to keep residents safe.

The inspectors found that, while the standard of care and support had improved in some areas, risks relating to IPC and staff training were not identified and managed appropriately, and some of the scheduled audits to oversee IPC, safeguarding, and incident management were not evidently implemented. Communication systems between managers and staff also required significant improvement to ensure timely, accurate and accessible sharing of information between key stakeholders.

The following sections of this report describe the governance and management

arrangements in the centre, and how these arrangements, while improving in some aspects of care and support, have failed to identify and respond to some risks in the centre.

Capacity and capability

This centre was last inspected in December 2022, following receipt of representation from the provider in response to a notice of proposal to cancel the registration of the centre. At the time of the last inspection the provider had demonstrated improvements in the quality of care and support provided to residents, and had a number of proposed governance arrangements to improve the oversight of the services in the centre. The purpose of this inspection was to monitor the progress the provider had made on their own quality improvement plan, their progress on the proposed governance and management arrangements, and the impact of these changes on the quality and safety of the care and support provided to residents.

The inspectors found that some of the proposed governance and management changes were implemented; however, there continued to be ineffective oversight of aspects of the services provided, specifically staff training, infection prevention and control (IPC), safeguarding, and incidents and accidents. This was compounded by an ineffective communication and reporting system between managers, and a lack of follow through on some actions identified by the provider, either through audits, or through their own quality improvement plan.

There were sufficient staffing levels in the centre, and while there were some vacancies in the centre, continuity of care was being maintained through the deployment of staff from the day service who were familiar with the needs of the residents.

Significant improvement was required in the provision of staff training, and staff had not been provided with a number of initial and refresher IPC trainings, as well as refresher training in Children's First.

Overall, the inspectors found the provider did not have effective systems in place to anticipate and respond to regulatory requirements and ongoing public policy developments, and to identify, monitor, and respond to risks in the centre.

Regulation 14: Persons in charge

There was a full-time person in charge in the centre, who continued to be supported in their role by a clinical nurse manager. The clinical nurse manager was based in the second centre, under the remit of the person in charge. There was one team leader in this centre, and one team leader vacancy, and recruitment was near

completion for this post.

The person in charge worked five days a week, and attended the centre each morning for approximately four hours. The person in charge had been in post since November 2022.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff employed in the centre, with the right skills and experience to meet the needs of the residents. There were some staff vacancies in the centre, including a social care worker and a healthcare assistant, and recruitment for these posts was actively underway. In the interim, a panel of relief staff from day services, as well as regular staff, filled additional shifts, which meant that staff familiar to residents needs were available to provide a consistent service to residents.

There was one staff on duty from 8.00 to 21.00 hours, and a staff worked at night from 21.00 to 10.00 hours. In the afternoon a staff worked from 15.00 to 22.00 hours. This meant that there were always two staff members on duty during the day when all residents were in the centre, and one staff at night time. Two days a week, the centre closed for a few hours, as all residents attended day services on these days. At the weekend two staff worked all day, one from 8.00 to 21.00 hours and one from 10.00 -22.00 hours. The person in charge also worked in the centre Monday to Friday from 9.00 to 13.00 hrs.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had not ensured that staff had training and refresher training in relation to infection prevention and control (IPC), and Children's First. For example, training records indicated staff had not completed training in respiratory and cough etiquette, and in transmission based precautions. Similarly staff had not completed training in food safety, and in cleaning and disinfecting the healthcare environment and patient equipment. Some training was out of date, including one staff in Children's First, four staff in hand hygiene, most staff had not had refresher training in donning and doffing PPE for approximately three years, and two staff had not had training in IPC since June 2020. The centre's IPC policy did not set out the requirements for the type and frequency of training.

Refresher training in risk management had recently been provided to all regular staff

and one relief staff in the centre, and all staff had up-to-date training in fire safety, manual handling, medicines management, safeguarding, positive behavioural support and therapeutic techniques and in feeding, eating, drinking and swallowing (FEDS).

Judgment: Not compliant

Regulation 23: Governance and management

While there were ongoing changes in the organisation, the provider had failed to ensure the mechanisms they proposed to ensure the effective oversight of the service, were wholly implemented in practice, and were capturing all aspects of service provision. Similarly, communication systems between key stakeholder required significant improvement to ensure up-to-date information was available, in order to identify issues and respond accordingly.

The inspectors met with the registered provider representative, the person in charge, the team leader, and two staff members over the course on the inspection. Inspectors also reviewed minutes of meetings, the centre's quality improvement plan and a range of audits.

The centre's quality improvement plan (QIP) which had been initiated a number of months ago, continued to be implemented, and was reviewed at monthly intervals. Actions were developed for identified issues, and the majority of actions were completed within the time-frame, with some actions not due for completion yet. However, there was no evidence to support an action had been completed, specifically, adding the QIP to the agenda of monthly staff meetings, and that individual support meetings had commenced with staff. The inspectors noted there had been only one staff team meeting since the last inspection, which had taken place in February 2023.

While audits had been delegated to the staff team, in line with an action from the QIP, there was no evidence to support that some of these audits had been completed. For example, monthly incident and accident audits, and monthly safeguarding audits. This meant that, the systems the provider had proposed to monitor risks which had been previously been highlighted as concerns in the centre, were not being implemented. A six monthly unannounced visit by the provider had been completed in January 2023, and a safeguarding audit identified as required within 3 weeks of this review, was not completed. Similarly, a three monthly IPC audit which the person in charge stated had been delegated to a staff member, had no evidence to confirm it had been completed.

While a number of audits had been completed, for example, a monthly financial review, complaints audit, and a HIQA self-assessment for IPC, the issues identified on this inspection were not highlighted within audits, for example, IPC issues and staff training. This meant that the provider did not have effective systems in place to

monitor all aspects of service provision, and to identify and respond to issues.

An annual review of the quality and safety of care and support had been completed for 2022.

As mentioned, resources in terms of staff training required improvement. Notwithstanding this issue, there was sufficient resources in terms of staffing, premises and transport.

There was a defined management system; however, communication and reporting between managers required improvement. Specifically on the day of inspection, a number of documents including minutes of meetings, audits, and staff training records were not readily available. Some documents were later located in the main organisation's office, and day services, and some documents while reported as being complete, were not available. This meant that the person in charge was not accessing up-to-date information in order to inform the effective administration and operational management of the centre. In addition, the inspectors found in the absence of some documentation, the assurances the person in charge required to ensure a safe and effective service, or respond to risks, were not available, and evidently not being used in the centre.

Three new members had been recruited to the board of directors, and training had been provided by an external company to all board members in February 2023. Training had included the roles and responsibility of board members, as well as an overview of legislative requirements. There had been one board meeting in January 2023, and incidents and safeguarding concerns had been reviewed at this meeting, as well as finances, upcoming training, and complaints. One action relating to board members accessing service policies and the centre's QIP arose, and the registered provider representative told the inspector this action was in progress, and the board of directors was due to meet the following week.

The provider had continued to engage the services of an external consultant, and minutes from the last meeting in January 2023 were reviewed by inspectors. An action arising from this meeting was for mandatory training to be identified for staff early and dates to be scheduled; however, given the significant issues with training, it was not evident that learning was taking place.

The registered provider representative, the person in charge and the clinical nurse manager met every two weeks, and a set agenda included discussions on the oversight of the service, staffing, safeguarding, incidents, and the centre's QIP. The measures implemented following safeguarding and adverse incidents were discussed at this meetings, and agreement on actions recorded.

The inspectors spoke to three members of staff, who stated they could raise concerns with the person in charge on the quality and safety of care and support if the need arose.

Judgment: Not compliant

Quality and safety

While residents appeared to have a fulfilled life, and the day to day care and support was provided in line with residents' needs, practices and policies relating to infection prevention and control (IPC) were not at a satisfactory standard to ensure residents who may be at risk of a healthcare acquired infection (HCAI) were protected. Some improvement was also required in risk management and in the timely development of personal goals for residents.

Residents needs had been assessed by the staff team, and healthcare professionals, and personal plans were developed based on these needs and residents' wishes. Most plans were reviewed regularly; however, the development and review of some residents' goals required improvement.

Residents had timely access to a range of healthcare professionals, and were provided with appropriate healthcare support in the centre, as was recommended.

Residents were supported with their emotional needs, and the recommendations outlined by a behaviour support specialist were detailed in behaviour support plans and were implemented in practice. Restrictive practices were recorded each time they were implemented, and practices were discussed with residents and regularly reviewed.

There had been some safeguarding incidents reported to HIQA, and these incidents had been reviewed, and reported to the relevant authorities. Safeguarding measures were implemented following incidents, to reduce the risk of potential harm to residents.

Residents' rights were promoted through practices in the centre, and residents had the freedom to choose how they wished to live their life. The day to day organisation of the centre was centred around the choices and needs of residents such as social activities, going to day services, or visits home to families. The facilities in the centre ensured residents had access to private space, and intimate care interventions promoted the privacy, dignity and preferences of residents.

Regulation 26: Risk management procedures

Risks within the centre had been identified and assessed, and risk management plans were implemented to mitigate the risk of harm to residents, visitors and staff. For example, an assessment by a speech and language therapist had been completed for residents at risk of choking, behaviour support plans were in place where risks of aggression had been identified, and residents had been given the opportunity to avail of vaccination programmes such as COVID-19, pneumococcal,

and flu vaccine.

Risk measures related to fire safety had also been implemented, and timely fire drills had been completed with residents and staff on a monthly basis.

There was also a centre risk register which had been reviewed in November 2022; however, this required review to ensure information was updated in line with review and development of centre and individual risks assessment.

The inspectors reviewed records of incidents since the last inspection, and all incidents had been followed up by the person in charge and by a healthcare professional if required. Staff had implemented the agreed procedures at the time of incidents. The inspectors spoke to a staff member who told the inspectors they had attended training on risk and incident management, and described how risks should be managed, and the reporting procedure if any risks were identified.

Judgment: Substantially compliant

Regulation 27: Protection against infection

As mentioned the provider had developed an IPC policy, which outlined some of the measures to be implemented to prevent and control infection in the centre. However, the policy did not outline the staff training requirements, and as discussed there were significant issues with staff training in IPC in the centre. The provider had a contingency plan, which the person in charge acknowledged was out of date, and the up-to-date version was not available in the centre.

Individual risk assessments had been developed for residents relating to IPC; however, measures outlined referred to individual contingency plans for residents, which were also not available for review on the day of inspection. The public health guidance available in the centre was not in date. This meant the information staff needed to guide practice in the response to a suspected or confirmed case of a communicable infection was not available in the centre. Similarly while two staff were identified as IPC leads in the centre, one of these staff did not work in the centre, and the other staff did not evidently have some IPC training completed.

An inspector was shown around the centre by the team leader, and overall the centre appeared visibly clean; however, some improvement was required in the maintenance of the centre. Floor tiles on two ensuite floors were damaged and worn, and the team leader explained this was due to the level of heavy cleaning required to remove limescale. Given that the surface was damaged, effective IPC cleaning could not be completed. The registered provider representative was aware of the issue, and outlined they had enquired as to the work required; however, there was no plan in place to complete this work. Rust was observed on a radiator and mirror in one ensuite, and two wall tiles were broken off another resident's bathroom wall.

The inspectors reviewed the cleaning records and cleaning arrangements in the centre. All records were complete for daily, and weekly deep cleaning of the centre. The IPC policy outlined that colour-coded cleaning cloths were recommended for bathrooms, kitchen areas, and general areas; however, the kitchen and general areas were not cleaned using different coloured cloths in line with the IPC policy. A staff member stated they were not aware that this was required. Colour coded mops were in use for different areas of the premises, and the staff member outlined that one coloured mop bucket was in the process of being replaced.

Satisfactory arrangements were in place for the disposal of clinical and general waste, and for the management of used linen. Medicines kept in the centre were stored in hygienic conditions, and medicine storage presses and containers were cleaned weekly.

Food safety procedures included daily checking of fridge and freezer temperatures, and of cooked foods, and all records were found to be complete.

Staff were observed to wear PPE during the day, and a staff member told the inspectors that face masks are worn by staff at all times when residents are in the centre. There was sufficient personal protective equipment (PPE) in the centre, and this was also stored appropriately. There were satisfactory hand hygiene facilities in the centre including wall mounted, and bottles of hand sanitiser, hand washing sinks and disposable hand towels.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' needs had been assessed and personal plans were developed based on the assessed needs of the residents. Some improvement was required to ensure personal development goals were reviewed and updated in a timely manner.

The inspectors reviewed two residents' plans, and found assessments were updated as residents' needs were reviewed with healthcare professionals. Personal plans were developed based on these identified needs, and specified the support to be given to residents to meet their needs. Plans included healthcare plans, intimate care plans and personal goal plans, and regular review of these plans were completed. Residents met with their keyworker monthly, and discussed progress of their goals; however, some improvement was required to ensure some residents' goals were developed into plans once identified.

Annual review meetings with residents, their family members, and staff had been facilitated and a review of residents' needs and personal plans were discussed at these meetings.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were met through timely access to healthcare professionals, and the ongoing monitoring of their healthcare needs. Residents had an annual review of their healthcare needs with their general practitioner (GP), and had access to a range of professionals such as a physiotherapist, optician, speech and language therapist, dentist and chiropodist. Regular reviews with allied healthcare professionals had been facilitated, and healthcare plans were updated based on the recommendations made by professionals.

Recommended healthcare interventions were found to be implemented, for example, daily physiotherapy exercises, and a FEDS plan. Residents' healthcare needs were monitored on an ongoing basis for example, scheduled blood tests were completed, and residents' blood pressure was monitored as recommended

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported with their behaviour and emotional needs, and could access the services of a psychiatrist and a behaviour support specialist. Behaviour support plans were developed by the behaviour support specialist, and were in line with risk assessments. Behaviour support plans outlined the proactive and reactive supports to help residents manage their emotions, and to ensure their safety. During a recent incident, staff had provided support to residents, in line with a behaviour support plan.

Staff had up-to-date training in positive behaviour support, and in the use of therapeutic techniques.

There were some restrictive practices in use in the centre, and these had been discussed with the residents concerned prior to implementation. Records were maintained each time a restrictive practice was used, and the circumstances for use of restrictions were clearly set out in personal plans.

The provider had previously outlined their intention to establish a rights review committee, whereby restrictive practices would be reviewed quarterly. While this committee had yet to be established, there was evidence from minutes of a management meeting, that this initiative was still ongoing, and was awaiting the recruitment of some personnel.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by policies and procedures in the centre. A number of safeguarding notifications had been made to HIQA since the last inspection, and incidents had been reported to the relevant authorities. All incidents had been reported at the time to the on call manager, and were reviewed by the person in charge. Safeguarding measures were put in place following incidents, and staff members described some of these measures. Where required, reviews had been facilitated with healthcare professionals, and recommended changes to support plans were implemented.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were promoted in the centre, and residents participated in decisions about their care and support, and about the organisation of the centre. The privacy and dignity of each resident was respected through practices in the centre, and the choices of residents formed the basis of the day to day operation of the centre.

Residents chose how they wished to spend their day, and some residents went to day services every day, and a resident chose to go the day services on a sessional basis. Where a resident had asked for a change of day service, this had been facilitated by the provider. The centre had recently been repainted, and residents had chosen the paint colours in their rooms, as well as some soft furnishings, and on the day of inspection, one resident was going shopping to pick some new furnishings to finish decorating their room.

Residents met with their keyworker every month and chose new activities they would like to attend, or new skills they would like to learn. For example, gardening skills, going on holiday, or going swimming, and in the main plans were developed and implemented to ensure residents were supported to achieve these goals. Residents also sometimes chose not to pursue some identified goals, and this choice was respected.

The choices and needs of residents formed the day to day organisation of the centre. For example, where a resident was not attending day services, staff were on duty, and supported the resident with social outings in the community. In the evenings and at weekends some residents liked to visit their families, and for other residents, they liked to go out shopping or for a meal, and these choices were facilitated. In a recent development, a resident had been part of the interview panel

for new staff. This meant the resident was actively involved in the decision making process for recruitment of staff to the centre.

Residents had participated in decisions about their care and support, for example, the use of restrictive practices, and the reason for these practices had been discussed with residents before they were implemented.

Each resident had their own bedroom, and ensuite bathroom, meaning their privacy and dignity was respected when they were supported with their personal care. Intimate care guidelines also outlined the preferences of residents, and the support needed to ensure residents' choices and privacy was upheld.

Judgment: 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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Steadfast House Residential Service - Group Home OSV-0001631

Inspection ID: MON-0035008

Date of inspection: 22/03/2023

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Provider/Person in charge has in place the most up to date Infection Prevention and Control Policy. All staff have been provided with opportunities to become informed with it's contents. The Provider has sourced a Staff Training Matrix from HSE Cavan/Monaghan to support Training and staff development. All Staff have up to date Training in Children's first and this will be evident on staff training file. Identified HSE Land training will be completed by 31st May 2023. This will include AMRIC basics IPC, Respiratory Hygiene & Cough Etiquette, Standard & transmission based precautions, Hand Hygiene for all staff and PPE. Mandatory Training in First Aid has been scheduled for 17th May for 4 staff and 2 staff requiring Patient Handling for 22nd May 2023. All training going forward will be identified by PIC from the Training Matrix and included in the QIP. Food safety training for Residential Staff - a confirmed date for HACCP has been received today for 13th & 16th June 2023. Training requirement pertaining to environmental hygiene protocol has been completed by all Staff.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Safeguarding, incidents and I.P.C. Audits have been completed and in future	

documented evidence will be made available for Provider inspection.
Quarterly IPC Audits will be scheduled by dates for completion and inspection.
All documentation pertaining to each facility will be secured on site, including Quality Improvement Plan.

The Provider representative meets the PIC and CNM1regularly, daily in some events. Formal scheduled meetings to discuss service provision are minuted and available on site, these include Staff meeting, Management meeting and meeting with External Consultant. Board meetings are recorded and retained at the Company's registered office. QIP is discussed at all meetings, staff input is encouraged and appreciated, up dated QIP is available at the Residence for staff information. Recently QIPs have been forwarded prior to Board meetings to enable greater scrutiny by Board Members and more meaningful discourse at meetings. As identified actions are completed on the QIP, these are now exited from the next QIP. Information on Staff scheduled training is provided to Board Members as part of the Managers report under the agenda item 'STAFF' The Provider's Compliance Plan is made available to Board Members. The Provider's external Consultant has been involved in all recent Compliance Plans and QIP's discussed at consultation minuted meetings. Agreed at the most recent Board meeting, that the Board Member with nursing qualification will engage with compiling the Providers Unannounced six monthly assessment report due shortly.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A satisfactory review of the centre's Risk Register has been completed by the Person in Charge. This is supported by up to date information on developments and any individual needs identified.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
All staff training requirements have been identified and scheduled for implementation.
Provider Contingency Plans are available at the centre and Residents IPC protocol updated and evidenced based.
Advice sought on how to address damage to Floor Tiles has been agreed and the process

commenced. Wall tiles and Rust areas have been replaced and repaired.
Equipment to comply with Providers IPC Policy has been purchased and available at the centre.

Up to date Public Health guidelines are available to staff. The Person In Charge has been tasked with keeping staff informed as guidelines change.
A schedule of IPC mandatory training has been undertaken by staff to date majority of which has been completed at time of writing.

This schedule is in line with Providers IPC policy.
An IPC lead has been identified for the facility by the Provider

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:
All resident's individual assessment and personal plans have been reviewed with emphasis on resident's input to goal setting and this process has been completed.

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 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	31/05/2023
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	Orange	09/05/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an	Not Compliant	Orange	12/05/2023

	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.			
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.	Substantially Compliant	Yellow	09/05/2023
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	Not Compliant	Orange	31/05/2023

	associated infections published by the Authority.			
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	12/05/2023