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:	The Beeches
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	22 June 2022
Centre ID:	OSV-0002342
Fieldwork ID:	MON-0035731

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:	8

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 June 2022	10:00hrs to 17:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced risk inspection scheduled to monitor the provider's progress in coming into regulatory compliance. The most recent inspection of the designated centre in December 2021 had identified high levels of non-compliance. A cautionary meeting was subsequently held with the provider and the provider submitted a comprehensive, time-bound plan which detailed the actions they would take to come into compliance. This inspection aimed to verify that those actions had been achieved or were in progress.

The Beeches is a large house located in a suburb of North Dublin and is home to eight residents. However, only seven of these residents currently live there full time. One resident has resided with a family member since the onset of the COVID-19 pandemic. The inspector saw, on arrival to the centre, that a staff was maintaining the flowerbeds to the front of the house. On entering the premises, the inspector saw that it had been freshly painted and looked well maintained.

The inspector was greeted by a staff member and a resident. The inspector saw that staff were wearing appropriate personal protective equipment (PPE) in line with current public health guidance. There were face masks and hand sanitiser available by the front door for use by visitors. Staff informed the inspector that they completed COVID-19 symptom checks with visitors on arrival.

Some residents were already at day services on the day of inspection while others were getting ready to go to their day services. The inspector had the opportunity to meet two residents before they left. One of these residents engaged in conversation with the inspector however they did not have access to their required communication supports. This resident was able to tell the inspector through Lámh that they loved their home however the inspector was unable to understand the rest of the information that the resident tried to communicate. Staff provided the inspector with a copy of this resident's communication passport however it was insufficiently detailed to support the conversation.

Staff informed the inspector that they were attempting to implement communication guidelines for residents however they had not received specific training and support in this area.

Two residents were unwell on the day of inspection. One had chosen to stay at home while the other returned from their day service early. The inspector saw that staff responded to these residents' needs in a kind and caring manner throughout the day.

There was a visual board with information regarding the meal of the day and the staff on duty located in the kitchen. However, the inspector saw that the photo of the meal of the day did not reflect what was on the menu. Additionally, several staff

photographs were missing from the staff board.

Residents were offered the opportunity to go out on the bus for a drive and a coffee after their day services. The inspector had the chance to speak to some of these residents before they left. Residents informed the inspector that they had recently had the opportunity to progress some goals which had been on hold due to the COVID-19 pandemic, including visiting loved ones.

The provider had filled the housekeeping and chef vacancies in the designated centre. The inspector spoke to the chef who was informed regarding residents' feeding, eating, drinking and swallowing (FEDS) care plans. A menu was compiled for the week based on residents' choices at resident meetings. However, it was not clear how residents with complex communication needs were consulted regarding this.

Additionally, the menu plan did not always reflect what residents were offered on a particular day. For example, hot dog and chips were on the menu for one day. This would not have been in line with residents' assessed FEDS needs. Staff and the chef described alternatives that residents were offered and these were documented on residents' daily care notes. However, it was not recorded on the visual menu for the week.

The provider had installed a new kitchen which was seen to be bright and clean. A new shower trolley and shower bed were in the large accessible bathroom. These were seen to be used to store toilet paper and intimate care products. There was a wider issue evident in relation to storage in the designated centre. A spare bedroom was also being used to store significant quantities of PPE. The person in charge informed the inspector that a new shed had been ordered and that they planned to reduce the amount of PPE stored in the centre.

Overall, while it was clear that the provider had made progress in coming into compliance in terms of staffing and premises, there remained several areas of regulatory non compliance. The inspector saw that staff engaged with residents in a caring manner however it was not evidenced that residents' rights were being upheld particularly in the areas of communication, dignity and autonomy.

The next two sections of the report set out the findings in relation to the governance and management arrangement arrangements in place and how these impacted on the quality and safety of care in the designated centre.

Capacity and capability

This inspection was an unannounced inspection, the purpose of which was to monitor the progress the provider was making in coming into compliance with the Regulations. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service and how effective it was

in ensuring that a good quality and safe service was being provided.

The inspector found that that the provider was in the process of implementing the measures, as set out in their compliance plan response to enhance the oversight of the designated centre. A new person in charge had been recently appointed. The person in charge was employed in a full time capacity but had oversight of an additional centre for a defined period of time. The provider expected that from the start of July 2022, the person in charge would have sole oversight of The Beeches.

The person in charge had received a handover on commencement of their post and was well informed regarding the presenting risks and issues in the designated centre. They had already implemented procedures to support enhanced oversight of the designated centre. These included delegating roles and responsibilities to staff members and completing staff supervisions with all staff.

The person in charge had submitted the required prescribed information to the Chief Inspector. They were found to be suitably qualified and experienced.

Several staff vacancies had been filled including part-time positions for a housekeeper and chef. At the time of inspection there was one 0.5 whole time equivalent vacancy. A planned and actual roster was maintained. A review of these demonstrated that staffing levels were in line with the statement of purpose. A small panel of agency staff was maintained in order to fill any gaps in the roster. This supported continuity of care for residents.

The levels of compliance with mandatory and refresher training for staff had increased compared to the previous inspection. However, there remained some training deficits, particularly in the areas of environmental first aid and positive behaviour support. A staff supervision schedule was in place. All staff had received a supervision session with the person in charge and a schedule was in place for the remainder of the year. A review of the minutes of staff supervisions detailed that they were appropriate to meet the needs of the staff. Staff reported that they felt supported in their roles. The inspector spoke to a recently appointed staff member who stated that they felt there was good communication amongst the team.

The provider had implemented a series of audits to support oversight of the designated centre. These included an annual review, six monthly review and monthly audits of areas such as medications and restrictive practices. The inspector found that the quality of these audits had been significantly enhanced subsequent to the last inspection. Audits were now found to be comprehensively identifying the risks in the centre and set out specific, time-bound plans to address these. Some of the time-frames for implementing actions were, however, found to be unrealistic as further support was required to effectively implement them. For example, the inspector saw that a risk in relation to residents' communication supports was to be addressed by March 2022. However, significant support was required in order to achieve this and it remained outstanding at the time of inspection.

The annual review set out that it had engaged with residents to elicit their views on the quality of service. However, the annual review acknowledged that it was difficult to capture the voices of residents with communication difficulties and identified that

a goal for the coming year would be to enhance communication systems in the designated centre.

Provider audits accepted that there remained high levels of non compliance in the centre and that significant actions were required to address these. Several areas were identified as requiring improvement. These included the premises, consultation with residents, residents' communication systems and access to the back garden.

The statement of purpose for the centre was reviewed. It was found to contain most of the information as required by the Regulations. however, the registration conditions required amendment in order to be wholly accurate.

Overall, the inspector found that the provider had enhanced their oversight of the designated centre and had systems in place to identify and respond to risks. However, there remained a significant number of non compliances which required addressing in order to ensure that residents were in receipt of a rights based and person-centred service.

Regulation 14: Persons in charge

The provider had appointed a person in charge in a full-time capacity. The person in charge was found to be suitably qualified and experienced.

The person in charge had oversight of an additional designated centre at the time of inspection. The provider set out that this was an interim arrangement and that by July 2022, the person in charge would have responsibility only for oversight of The Beeches. There were measures in place to support the person in charge in having oversight of both designated centres.

Judgment: Compliant

Regulation 15: Staffing

The provider had filled several staff vacancies including those in housekeeping and catering. There was one 0.5 whole time equivalent vacancy at the time of inspection.

A planned and actual roster was maintained. The inspector saw that the staffing numbers and skill mix were as per the statement of purpose and were suitable to meet the assessed needs of the residents.

Gaps in the staff roster were filled from a small panel of regular agency and relief staff. This supported continuity of care for residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to regular quality supervision. A supervision schedule was in place which set out that staff would be in receipt of supervision regularly and as prescribed by the provider's policy.

Staff reported to the inspector that they felt supported in their roles and that they were aware of their specific responsibilities.

The levels of compliance with mandatory and refresher training had increased since the last inspection. However, there remained areas where refresher training was required. These included:

- Fire safety: 73% of staff had completed this
- COVID-19: 73% of staff had completed this
- Environmental first aid: 62% of staff had completed this
- Positive behaviour support: 64% of staff had completed this

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had enhanced their oversight of the designated centre. There were a series of audits in place which accurately reflected the presenting risks and set out a time-bound plan to address these. The time-frames for some of the actions required review to ensure they were realistic and achievable.

The annual review set out that consultation had been completed with residents however it was unclear how some residents with complex communication needs had been supported to engage with this. Enhancements were required to ensure that all residents' experiences and views were adequately captured and used to inform service planning.

The provider had appointed a person in charge who was employed in a full-time capacity.

There were mechanisms in place to ensure that staff were adequately supported and performance managed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place which contained the information as required by Schedule 1 of the Regulations. However, the registration conditions were inaccurate and required amending.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality of the service and how safe it was the residents who lived in the designated centre. The inspector found that the provider had taken action to address high level risks to ensure that the centre was operating in a safe manner. However, significant improvements were required to ensure that residents were in receipt of a quality service which was operating in a person-centred manner and which was respectful of individual residents' rights. The inspector saw, through reviewing audits, that the provider was aware of the presenting risks in relation to residents' rights, communication and autonomy. However enhancements were required to ensure that these risks were addressed.

Several premises issues were identified on the last inspection in December 2021. The inspector saw that many of these had been addressed. A new kitchen had been fitted and the centre was freshly painted. The centre appeared bright and welcoming on arrival. There were some outstanding premises issues including the replacement of a carpet. There was also an issue with storage in the centre. One room was being used to store large quantities of personal protective equipment (PPE). The person in charge stated that a new shed had been ordered to store this equipment.

The inspector also saw that a shower bed was being used to store toilet paper and hand towels in the downstairs bathroom. This was attributed by staff to insufficient storage. The person in charge was aware of the storage issues and set out that they had plans to address this.

There remained a restrictive practice in place which impacted on several residents. This restrictive practice limited residents' access to their downstairs sitting room when it was required by one resident in line with their positive behaviour support plan. While residents had access to another sitting room which was located upstairs, this was not their preferred area to relax as they preferred to be downstairs in the company of staff.

The inspector saw evidence that the provider had recently obtained approval to proceed with seeking planning permission for an extension to the centre. This would provide a living space for one resident who required it and allow all other residents

to access the main sitting room. There was no definitive time frame in place for this to be achieved.

The inspector reviewed the notifications received in relation to peer to peer incidents over the previous six months. It was noted that there had been a significant reduction in the number of peer to peer incidents of abuse. However, incidents between residents continued to occur and it was evident that the reduced availability of individual quiet space in the centre was a contributing factor to these.

The person in charge also informed the inspector that they planned to convert a spare bedroom into a sensory room. This would allow for an additional quiet space for those residents with sensory needs.

Restrictive practices which were in place in the centre were logged and were regularly audited. They were also notified to the Chief Inspector in line with the regulations. Positive behaviour support guidelines were available for those residents who required them. These were found to be have been recently reviewed and were written in person centred language. Staff were familiar with the content of behaviour support plans.

Safeguarding incidents were also recorded and notified to the relevant statutory agencies. The inspector saw that interim safeguarding plans were implemented subsequent to any allegations of abuse in the designated centre. There was evidence that debriefing conversations were held with residents subsequent to any incidents of abuse.

Enhanced oversight of the safeguarding process was required as the inspector saw that, in some cases, the safeguarding team had requested additional information following on from the first safeguarding report. It was not evidenced that the safeguarding team's requests were followed up on in a timely manner. For example, the inspector saw a request for information on the 5th of May 2022 in relation to one incident. It was not evidenced that this information was provided at the time of inspection.

Residents' rights and communication supports were areas identified as requiring significant enhancements both by the provider, through their audits, and by the inspector. The inspector saw that the provider was now holding regular residents' meetings. However, it was not clear how residents with complex communication needs were being supported to participate in these meetings and therefore, how there were consulted regarding the day to day running of the centre. The inspector saw that the menu board, as chosen at weekly residents meetings, only reflected some residents' choices in relation to foods while other residents were offered different meals due to their assessed needs.

As previously discussed, there were several restrictive practices in place which impacted on the rights of residents to access all parts of their designated centre. The provider's rights committee acknowledged in reviewing this restrictive practice that it constituted a rights restriction. There were plans in progress to extend and re purpose some of the rooms in the designated centre however this had not been

achieved at the time of inspection and there was no clear time frame for doing so.

The inspector also saw that residents' assessments of need identified that residents needed support to learn about rights. A rights support plan was in place for one resident. This had been updated in February 2022 and set out that the resident required visuals to communicate and to exercise their rights. The visuals available on the day of inspection were ineffective in supporting communication between the resident and the inspector

Other communication guidelines detailed that residents used augmentative and alternative communication (AAC) including high tech devices, applications and switches. These were found to be inaccessible or missing on the day of inspection. Some residents used Lámh to communicate however staff had not received training in this area.

One staff member described how they were attempting to support residents' communication through intensive interaction however they had not received any training and had limited guidance from an appropriate multi disciplinary professional in doing so. The inspector was informed that staff were on a waitlist for intensive interaction training.

A sample of residents' files were reviewed. The inspector saw that residents each had an up-to-date assessment of need. The assessment of need was used to inform care plans. These were written in person centred language. It was also evidenced that consultation took place with residents, their representatives and multi-disciplinary professionals in order to update the assessment of need and associated care plans.

The inspector saw that residents now had access to day services and that there was increased opportunity for residents to engage in meaningful occupation. A review of residents' daily notes demonstrated that residents had the opportunity to engage in activities at home and in the community. Residents had set goals for the current year and there was evidence that these goals were being progressed. One resident told the inspector that they were happy with their goals and how they were being supported. Some residents were planning a holiday over the summer.

There was an availability of wholesome nutritious food in the designated centre. A chef was available for 20 hours per week to support with meal preparation. Some residents had assessed feeding, eating, drinking and swallowing (FEDS) needs. Staff were aware of FEDS care plans. Meals were provided which were in line with FEDS needs however it was not evidenced that residents were offered choice in their meals. The weekly meal plan did not reflect the options available to residents who required modified foods.

The provider had effected policies and procedures in order to mitigate against the risk of residents acquiring a healthcare associated infection. Staff were aware of the provider's infection prevention and control (IPC) policies. The centre had an outbreak management plan and a contingency plan in the event of an outbreak of COVID-19. These had been recently reviewed and updated.

Staff were wearing appropriate personal protective equipment (PPE) in line with current public health guidance. There were inconsistencies however in staffs' knowledge of the safe removal and disposal of used PPE. Further oversight was also required of the availability and effectiveness of hand sanitiser in the designated centre. There was limited availability of hand sanitiser. The inspector also saw that many of the hand sanitising bottles were reusable bottles. It appeared that these were filled from a five litre drum of hand sanitiser which had expired in March 2022.

In summary, the inspector found that the provider was making attempts to come into regulatory compliance and to provide a person-centred service. The provider was aware of the presenting risks in the centre and had plans in place to address these. Improvements were required to these plans to ensure that they were specific and time-bound. In particular, improvements were required to ensure that residents' rights and their communication needs were appropriately supported.

Regulation 10: Communication

The registered provider did not have systems in place to ensure that residents were assisted and supported at all times to communicate in accordance with their assessed needs.

Staff were unfamiliar with some of the residents' communication support plans and their augmentative and alternative communication systems.

Assistive technology was not available or was not working correctly. Residents were not supported to use assistive technology in line with their support plans.

Staff required additional training and support in order to effectively support residents' communication in line with their assessed needs.

Judgment: Not compliant

Regulation 13: General welfare and development

Residents had access to increased opportunities for occupation and recreation. Residents were in receipt of day services, the frequency of which was in line with their assessed needs and wishes. The inspector saw that residents were supported to set goals and to achieve these.

Residents were supported to maintain personal relationships with their families and to access the community as per their wishes.

Judgment: Compliant

Regulation 17: Premises

The provider was in the process of addressing premises issues at the time of inspection. A new kitchen had been fitted and painting had been completed. There were some premises works which remained outstanding including fitting a new carpet on the stairs and enhancing the garden facilities to make them more appealing and accessible to residents.

However, in spite of the premises works, the inspector saw that the centre remained unsuitable to meet the assessed needs of all residents. This was due to resident compatibility issues and a lack of appropriate quiet space for some residents who required this in line with their behaviour support plans.

The provider set out that they planned to extend the premises and to re purpose unused bedrooms. However, there was no time-bound plan in place in this regard.

There was also an issue with storage in the designated centre. Action was required to enhance the storage facilities.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were provided with a range of food which were wholesome and nutritious.

Several residents had FEDS care plans in place. Staff were aware of these and were seen to support residents at mealtimes in line with their care plans.

A weekly menu was decided at residents' meetings and the meal of the day was displayed visually each day. However, the inspector was informed that residents with FEDS care plans often received a different meal. It was unclear how residents were being consulted with and offered choice in this regard.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had effected policies in order to reduce the risk of residents contracting a healthcare associated infection. However, improvements were required to some of the practices in place in the designated centre to ensure that policies and procedures were effective.

Staff were seen to be wearing appropriate PPE however there was a gap in staffs' knowledge regarding the safe removal and disposal of used PPE.

Enhancements were required to the availability of hand sanitiser and to ensure that hand sanitiser was in date and effective.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had an up-to-date assessment of need. The assessment of need was completed in consultation with residents, their representatives and multi-disciplinary professionals. Care plans were derived from the assessment of need. These were written in a person centred manner and were up-to-date.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required behaviour support plans had an up-to-date plan on file. Staff were aware of residents' behaviour support plans and were observed supporting residents in line with these. There were several restrictive practices in place in the designated centre. Restrictive practices were logged, regularly reviewed and notified to the Chief Inspector in line with the regulations.

Judgment: Compliant

Regulation 8: Protection

There was a significant reduction in peer to peer related incidents of abuse in the designated centre in the first six months of 2022, compared to the six months prior to this. However, there continued to be peer to peer related incidents and it was therefore not evidenced that the provider had systems in place to protect all residents from all forms of abuse. Peer compatibility issues were compounded by premises issues and the lack of appropriate space for residents to access.

Safeguarding incidents were logged and notified to the safeguarding team and to the Chief Inspector. Interim safeguarding plans were implemented. However, further oversight was required to ensure that requests for further information from the safeguarding team were followed up on in a timely manner.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The designated centre was not operated in a manner that ensured each resident's privacy and dignity was respected in relation to their personal living space and relationships. Some residents had care plans in place which stated that they required access to quiet space in order to manage their distress at particular times. This impacted other residents as they could not access their downstairs living room. This resulted in residents congregating in the kitchen which is where many of the peer to peer related incidents of abuse occurred.

Additionally, many residents in the designated centre required support with their communication as per their support plans. The inspector saw that residents did not have access to the required supports and that staff had not received training in residents' communication systems. It was therefore not evidenced that residents with communication needs were supported to participate in and consent to decisions relating to the running of the centre. It was unclear how these residents had freedom to exercise choice and control in relation to their daily lives.

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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for The Beeches OSV-0002342

Inspection ID: MON-0035731

Date of inspection: 22/06/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: · Training Audit review completed by Training Dept on the 30/6/2022 · Fire safety: all staff completed online training programme on the 22/7/2022 · Covid 19: all remaining staff completed their online training by the 22/7/2022 · Environmental 1st aid: two staff require face to face training and this will be completed by 30/9/2022 · Positive behavioral support training; Identified exemption for one staff previously identified on training audit due to role within the DC- Two staff completed Training online on the 22/7/2022	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: · Review of all timeframes by Service manager and PIC with agreed realistic and achievable timeframes for completion of all outstanding actions · As part of annual review process- Questionnaires are submitted to keyworkers to support residents through their specific communication styles in engagement this process. The process will be reviewed further under the scheduled Total communication training with staff. 30/9/2022 · Total Communication training by Speech and language Therapist with staff team to discuss and identify Communication support needs and formulate effective support plans to ensure residents involvement in their home- scheduled for 26th July 2022- Further meeting with Team on the 14th Sept and 21st Sept · Training of 5 staff in LAMH to facilitate those residents who use this tool format as part of their Communication style. 14/9/2022 · Residents meetings will continue every week and above input by SLT will inform and guide staff on effective and inclusive communication tools specific to assessed need.	

· For those residents who do not like the forum of weekly residents meeting 1;1 support meeting will be held instead with individual residents- and their level of engagement with this process will be assessed and documented for review.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: · Statement of purpose has been reviewed and now reflects all conditions of registration 19/7/2022

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication: · All residents who require Communication guidelines are in place- · Referral sent to SLT department with regard to support for Staff team in the implementation of these guidelines. Total Communication training by Speech and language Therapist with staff team to discuss and identify Communication support needs and formulate effective support plans to ensure residents involvement in their home- scheduled for 26th July 2022- Further meeting with Team on the 14th Sept and 21st Sept . · Training of 5 staff in LAMH to facilitate those residents who use this tool format as part of their Communication style. 14/9/2022 · Residents meetings will continue every week and above input by SLT will inform and guide staff on effective and inclusive communication tools specific to assessed need. · For those residents who do not like the forum of weekly residents meeting 1;1 support meeting will be held instead with individual residents- and their level of engagement will be assessed and documented for review.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: · Replacement carpet on the stairs- 30/8/2022 · Purchase of Gazebo for the back garden and replanting of all garden boxs outside to the back of the DC- 30/7/2022 · Review of upstairs accommodation with the development of an additional seating and sensory room 30/8/2022 · Planning application has been lodged – submission for Fire and Disability Access Certificates. The tender process to overlap. · Interim Director of Adult services/Director of operation- and Director of Estates for SMH to meet with HSE director of Estates · Dependent on funding approval- Plan for 1st phase of construction 31/1/2023 with a planned completion for 30/3/2023

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition: · Review of process for meal planning with identification of meal planned for that day-

choice available for some residents who may not wish to have this meal on that day- this determination is based on their indicated choice , through verbalizing, or {where for those with limited communication tools} they may refuse a certain type of meal in preference to another. Support documentation will reflect the review of these supports with regard to choice and the establishment of a pathway to facilitate.
· Meeting with Speech and language Therapist/ staff team to discuss and identify Communication support needs and formulate effective support plans to ensure residents involvement in their home- 26th July 2022-
· Further meeting with Team on the 14th Sept and 21st Sept- Will inform staff supporting residents to make informed decisions based on their preferences.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
· Infection control policy- Standard precaution PPE updated 30/6/2022- All Staff have signed as read and understood and aware of their role in the implementation
· Review of PPE guidance documentation with staff team on the 14/7/2022
· Training on Standard and Transmission Based Precautions have been developed and will be available on line for all staff from the 30/9/2022
· All PPE has been reviewed –hand sanitisers have been purchased with a shelf life of 17 months

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
· All residents have commenced return to day service provision since end of February 2022 and this has positively impacted on the engagements within the peer group.
· Review of upstairs accommodation with the development of an additional seating and sensory room 30/8/2022
· Planning application has been lodged – submission for Fire and Disability Access Certificates. The tender process at this stage can overlap.
· Interim Director of Adult services/Director of operation- and Director of Estates for SMH to meet with HSE director of Estates.
· Dependent on funding approval- Plan for 1st phase of construction 31/1/2023 with a planned completion for 30/3/2023
· All Preliminary safeguarding /Formal safeguarding documentation now on site for review and to inform all aspects of safeguarding planning

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
· Review of upstairs accommodation with the development of an additional seating and sensory room 30/8/2022
· Most of the residents prefer to congregate in the kitchen area, and review of Risk assessments and safeguarding plans completed 22/7/2022 to ensure all residents Will and Preference is taken into account-
· Safeguarding plans reflect that during periods of heightened behaviours within the DC

they will be facilitated to access alternative accommodation in the two sitting rooms upstairs.
· Planning application has been lodged – submission for Fire and Disability Access Certificates. The tender process will overlap.
· Interim Director of Adult services/Director of operation- and Director of Estates for SMH to meet with HSE director of Estates
· Dependent on funding approval- Plan for 1st phase of construction 31/1/2023 with a planned completion for 30/3/2023
· Total Communication training by Speech and language Therapist with staff team to discuss and identify Communication support needs and formulate effective support plans to ensure residents involvement in their home- scheduled for 26th July 2022- Further meeting with Team on the 14th Sept and 21st Sept .
· Training of 5 staff in LAMH to facilitate those residents who use this tool format as part of their Communication style 14/9/2022
· Residents meetings will continue every week and above input by SLT will inform and guide staff on effective and inclusive communication tools specific to assessed need.
· For those residents who do not like the forum of residents meeting 1;1 support meeting will be held with individual residents- and their level of engagement will be assessed and documented
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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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Red	30/09/2022
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/09/2022
Regulation 10(3)(c)	The registered provider shall ensure that where required residents are supported to use assistive technology and aids and appliances.	Not Compliant	Red	30/09/2022
Regulation	The person in	Substantially	Yellow	30/09/2022

16(1)(a)	charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Compliant		
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Red	30/03/2023
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	30/08/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/07/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/09/2022
Regulation 18(2)(c)	The person in charge shall ensure that each	Substantially Compliant	Yellow	30/09/2022

	resident is provided with adequate quantities of food and drink which offers choice at mealtimes.			
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Substantially Compliant	Yellow	30/07/2022
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.	Substantially Compliant	Yellow	19/07/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/09/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit	Substantially Compliant	Yellow	20/06/2022

	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 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/09/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	19/07/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of	Substantially Compliant	Yellow	30/03/2023

	abuse.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Red	30/09/2022
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	30/09/2022
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	30/09/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in	Not Compliant	Red	30/09/2022

	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.			