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:	Broadleaf Manor
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	14 November 2022
Centre ID:	OSV-0003397
Fieldwork ID:	MON-0032499

About the designated centre

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

Broadleaf Manor is a large detached residence located in a rural setting close to a small village in Co. Kildare. The property is subdivided into six separate living areas, four of which are self-contained apartments. The property is homely, well maintained, spacious and clean. The centre provides care and support to both male and female adults, all of whom require support around their mental health needs. The provider has supplied a number of vehicles in order to transport residents to their day services and to access local amenities. Residents are support by the staff team 24 hours a day seven days a week in line with their assessed needs. The staff team comprises of a person in charge, team leaders, deputy team leaders, social care workers and assistant social care workers. Residents have access to a range of allied health professionals in line with their assessed needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Monday 14 November 2022	10:00hrs to 17:00hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This unannounced inspection took place to monitor ongoing compliance with the regulations. From meeting with residents and what the inspector observed, it was evident that residents were being supported to engage in activities of their choosing in a safe environment. This inspection found mixed levels of compliance with the regulations, with some areas of good practice, and other areas which required improvement, particularly fire precautions, infection prevention and control and individualised assessments and personal plans.

The designated centre is a large two-storey house located in a rural setting in Co. Kildare. Downstairs, the house comprises a large hallway, three resident apartments, a communal kitchen/dining area, a sitting room, an office and a wet room. Upstairs, there are three resident bedrooms which are en suite, two staff sleepover rooms, an office and another self-contained apartment. Due to the complex support needs of the residents, the inspector found that some residents living spaces were highly restrictive and secured and this meant that some residents did not have freedom of movement within the centre without staff support. Other areas of the centre were found to be more personalised, with family photographs and personal affects accessible in residents' bedrooms in line with their assessed needs. Where possible, restrictions were reduced in line with residents' expressed wishes and their mental health and well being. There were examples of positive outcomes for residents such as a reduction in the ratio of staff they required and an increase in their independence relating to living skills.

Residents in the centre had access to their own vehicle. They were supported to attend and participate in various community-based activities such as day services, Tai Chi, tennis, golf, engaging in initiatives such as Tidy Towns and some residents were in supported employment. Residents were supported to maintain relationships with families and friends. A full games room was developed to support with recreational activities and gym equipment. The inspector had the opportunity to briefly engage with four of the residents and their support staff over the course of the inspection. Residents appeared comfortable in the presence of staff and some were engaging about their plans for Christmas and listening to Christmas music. Another told the inspector that they had been out for coffee with their support staff and they had plans to visit a chain of coffee shops around the country as part of their goal. Another resident was in their day service while another chose not to engage with the inspector.

All residents were assigned a key worker and they had a meeting once a month. These meetings were documented and included discussions on residents' goals and progress and discussions around restrictions. There was a weekly forum held with all residents and the minutes viewed by the inspector demonstrated that there was a standing agenda in place which included concerns, complaints and upcoming activities. Residents in the centre had access to an external advocate where it was

required.

The inspector viewed resident questionnaires which were completed by residents for the provider's annual review. The questionnaires noted that residents had mixed levels of satisfaction with their living arrangements and the menu on offer. Some wished to move and others reported to be unhappy with the food. Residents were aware of the complaints process and there was evidence of residents being supported to make complaints where they wished to do so. Residents met with the person in charge each day and this facilitated informal daily discussions about residents' plans, concerns or updates.

In summary, the inspector found that residents in the centre were receiving a good quality service, with specialist input in relation to their behaviour and mental health. They appeared comfortable and content in the company of staff and interactions between residents and staff was noted to be respectful and friendly. The next two sections of the report outline the governance and management arrangements in the centre and how these arrangements affected the quality and safety of care received by residents.

Capacity and capability

Overall, the provider had suitable governance and management arrangements in place to monitor and oversee the quality and safety of care for residents in the centre. There was a clear management structure in place which consisted of team leaders who reported to the person in charge and in turn, they reported to the deputy operations manager. There was a member of the local management team rostered in the centre seven days a week. There were a number of quality assurance tools and processes used to monitor key areas of the service such as safeguarding, incidents and accidents and complaints. The provider carried out an annual review and six monthly unannounced visits in line with regulatory requirements. In addition to these reviews, unannounced quality assurance audits took place regularly and these reports were given to the person in charge and the staff team. There was evidence to indicate that the provider was self-identifying issues requiring improvement. However, there was inadequate evidence to indicate that actions arising from inspections and provider audits were progressed in a timely manner to ensure ongoing quality improvement.

Staff meetings took place off-site regularly and the agenda included discussions about residents, safeguarding, policies and procedures and some opportunities to practice de-escalation and intervention techniques outlined in residents' support plans. Staff had the opportunity to attend meetings on alternate months to enable all staff on the team to have an opportunity to attend. Check -ins took place twice a day to ensure all staff supporting residents had the required information about how the resident was presenting, any incidents or accidents, safeguarding concerns and any additional information which was required.

The provider had ensured that the centre was adequately resourced with a large staff team to best meet residents' assessed needs. There were a significant number of vacancies on the day of the inspection and the person in charge was working in liaison with the human resources team and management to recruit to these posts. A review of actual and planned rosters indicated that shifts which were vacant were covered by staff members from the team or regular relief staff which enabled residents experience continuity of care.

The inspector viewed the staff training matrix and found that all staff had completed mandatory training in the areas of fire, safeguarding and supporting people with behaviours of concern. The person in charge in the process of carrying out a review of all residents' assessed needs to ensure that areas requiring additional training were identified and actioned. There were suitable arrangements in place in relation to staff supervision.

The inspector found that documentation required improvement in the centre. Throughout the inspection, there were a number of pieces of information pertaining to residents found on incorrect files. There was a need to ensure that documentation was reflective of current needs of each resident and their current circumstances. This is discussed in further detail below.

Regulation 15: Staffing

There was a team of 41 staff members which consisted of the person in charge, team leaders and deputy team leaders, social care workers and assistant care workers. There were a number of vacancies on the day of the inspection and the person in charge was working in liaison with the human resources team and management to recruit to these posts. A review of actual and planned rosters indicated that shifts which were vacant were covered by staff members from the team or regular relief staff which enabled residents experience continuity of care.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector viewed the staff training matrix and found that all staff had completed mandatory training in the areas of fire, safeguarding and supporting people with behaviours of concern. Centre specific training had been completed by staff in areas such as the provision of intimate care, self-harm and infection prevention and control. The person in charge in the process of carrying out a review of all residents' assessed needs to ensure that areas requiring additional training were identified and actioned. Supervision arrangements had changed since the last inspection, with staff members now receiving supervision every six months.

Judgment: Compliant

Regulation 21: Records

Documentation in the centre in relation to residents' care plans required improvement. The inspector found a number of documents over the course of the inspection which related to different residents filed in other residents' care plans. Some of the centre-related documents such as standard operating procedures had the incorrect name on it. The provider had self-identified documentation as requiring improvement on two recent audits. It was not clear what the status of the improvement plans were on the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had suitable governance and management arrangements in place to monitor and oversee the quality and safety of care of the residents in the centre. Provider level monitoring and oversight was achieved through a number of measures. A governance matrix was completed by the person in charge on a weekly basis to review key areas of the service such as safeguarding incidents, incidents and accidents and complaints. This was reviewed by the senior management team to ensure that any areas of concern were immediately addressed. The provider carried out an annual review and six monthly unannounced visits in line with regulatory requirements. The annual review for 2021 included the views of the residents. In addition to these reviews, unannounced quality assurance audits took place regularly and the report was given to the person in charge and the staff team. There was evidence to indicate that the provider was self-identifying issues requiring improvement. However, many of these areas remained unresolved on this inspection or it was unclear from documentation reviewed, what the status of actions were. Some of these items had been identified on a previous inspection and included ensuring residents' care plans were up -to-date, premises, IPC measures and gaps in documentation relating to health and personal plans.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents in the centre were receiving good quality care

which was striving to support them increase their independence, access community amenities safely and reduce restrictions. Improvements were required in healthcare, premises and individualised assessments and personal plans.

Each resident had a comprehensive needs assessment of need carried out each year. These were carried out by the person in charge. From a review of a sample of files, it was unclear whether or not a relevant health care professional had carried out or was consulted with in relevant areas of the assessment of need in line with regulatory requirements. Information in assessments required review to ensure they were in date and relevant to the residents' current assessed needs. Residents had personal and social goals which they set and reviewed regularly with their key workers. However, there was limited evidence to show a review of the effectiveness of residents' personal plans was carried out as required.

Residents in the centre were supported to maintain best possible health. They had access to a psychiatrist, a GP and other health and social care professionals such as a psychologist, behaviour specialist and a dietitian. Residents were supported to access HSE National Screening Programmes where they were eligible to do so. Nursing input was available within the organisation where it was required. Healthcare plans required review to ensure that all identified areas of need had corresponding care plans in place to address these needs and that the plans were reflective of the residents' current assessed needs. For example, one resident had a care plan in relation to a short-term condition they had a number of years ago and staff were unclear if this was still required. Another resident had been identified as requiring measures to reduce their risk of choking in their needs assessment. Measures in the assessment and risk assessments did not match the health management plan in place. This was required review to ensure the resident received care in line with their assessed needs.

Residents in the centre had complex behaviour support needs and had multi element behaviour support plans in place. These were developed and overseen by the behaviour specialist, a psychologist and a psychiatrist. Residents had individual risk management plans in place and these clearly outlined proactive and reactive strategies. Where residents were required to have PRN medication relating to their behaviour, there was a clear procedure in place to ensure that this was consistently and safely administered as required.

There were a high number of restrictions in the environment in addition to a number of restrictive practices for individual residents. These restrictions were reviewed regularly. Key working sessions involved discussions on the restrictions which were in place for residents and a discussion on what restrictions they were working towards reducing. The person in charge met with residents each day. There was evidence of clear criterion for the reduction of restraints to ensure the ongoing safety of residents and staff, while promoting independence and residents' rights. There was a system in place to ensure that any use of PRN medication or in appropriate use of restraints was reviewed by the behaviour team and actioned.

As outlined earlier in the report, for the most part, the premises was found to be suitable for the residents needs. They had access to a games room, a gym and a

back garden in addition to large communal and private spaces within the house. Where it was safe to do so, residents had personalised their spaces with family photographs or personal affects. The inspector identified some areas of the centre which required attention and these are outlined under Regulation 17 below.

There were a number of policies and procedures in place pertaining to safeguarding residents from abuse. These included a policy on vulnerable adults and a policy on the security of individual accounts and personal property. Personal and intimate care plans were found to be suitably detailed to guide staff practice. There were a high number of allegations of abuse submitted to the Authority in the 18 months prior to this inspection. The inspector found that for the most part, these were appropriately documented, reported and investigated. Some incidents were reported outside of the required time frames and the person in charge had put additional control measures in place in order to ensure the timely reporting of incidents.

There was a clear system in place for the identification, assessment, management and review of risks in the centre. The inspector viewed the risk register for the centre which was reviewed in line with the provider's time lines. Residents had individual risk management plans in place which outlined individual risks associated with residents. However, the risk register for the centre did not reflect ongoing risks relating to infection prevention and control such as the management of linen, the management of spillage of bodily fluids and for some individual risks relating to residents such as those who had self injurious behaviour who may require wound care.There was a system in place for responding to and reporting adverse events. There were a high number of incidents occurring in the centre. These were appropriately documented and reported in line with the provider's policies and procedures. Incidents were trended weekly and additional measures put in place where required. There was evidence of learning from incidents and this was discussed at daily handovers and in further detail at staff meetings.

The provider had implemented a number of measures to protect residents from healthcare-associated infections infection. Following an outbreak of COVID-19 in the centre, individual isolation plans had now been developed. Antibiotic logs were in use to inform antimicrobial stewardship within the service. There was an infection prevention and control policy (IPC) in place, but this required review to ensure it was suitably detailed to guide staff practice. Oversight and monitoring systems specific to IPC in the centre required improvement. Issues such as cleanliness and hygiene, suitable storage for residents' belongings, the identification, assessment and management of IPC risks and ensuring the premises was maintained to an adequate standard to enable cleaning and disinfection required action.

Fire safety management systems were in place in the centre , with fire fighting equipment, emergency lighting and detection and containment systems were in place. Residents had personal emergency evacuation plans in place. However, documentation and oversight of fire drills required improvement. This is detailed under Regulation 28 below.

Regulation 17: Premises

For the most part, the premises was found to have ample space for residents and it was well suited to their needs. The inspector completed a walkabout of the premises with the person in charge. There were a number of areas which were not clean or that were found to be in a poor state of repair. Observations included large stains on the ceiling in two rooms due to leaks which had occurred upstairs, a bathroom which was found to be dirty. The seal on the bath was damaged and the radiator was rusted. While this resident had complex support needs, there was a need to ensure that their living area remained clean and in a good state of repair. In another part of the centre, furniture required replacement to enable thorough cleaning and disinfection, although this had been ordered on the day of the inspection. Another bathroom needed attention in relation to cleanliness and waste disposal. Storage was found to be an issue for some residents with a significant amount of personal belongings stored in piles on the floor in two bedrooms. Residents were supported to personalise their space where possible, although in some spaces this was not possible or evident due to high levels of environmental restrictions in place.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were systems in place to identify, assess and manage risks within the service. The provider had a risk management policy which met regulatory requirements. Residents had their own individual risk management plans and the centre had a risk register in place. Individual risk management plans required improvement to ensure that all risks relating to residents was consistent with care plans. The provider had self-identified this as an issue in May 2022. Additionally the risk register for the centre required additional assessments relating to IPC risks such as the management of linen and managing body fluid spillages. Risks were regularly discussed with the staff team. There was a system in place for managing adverse events. Incidents were appropriately documented and recorded and learning was identified. Trending of incidents was carried out on a weekly and monthly basis by management and where required, additional measures were put in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had implemented a number of measures to protect residents from infection. Following an outbreak of COVID-19 in the centre, individual isolation plans had been developed. Antibiotic logs were now in use to inform antimicrobial

stewardship within the service. There was an infection prevention and control policy in place, but this required review to ensure it was suitably detailed to guide staff practice. IPC was not reflected in the provider's annual review and there was not evidence of a specific IPC audit taking place in the centre. The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed by the person in charge and reviewed every quarter. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. However, this did not self-identify some of the issues found on inspection. Areas such as cleanliness and hygiene, identifying IPC risks, ensuring the premises was maintained to an adequate standard to enable cleaning and disinfection required improvement.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had suitable fire safety management measures in place. There was equipment in place for the detection and containment of fire. Fire fighting equipment was available and emergency lighting was visible throughout the centre. Regular checks and servicing of equipment were taking place. However, fire drills required improvement to ensure that all residents could be safely evacuated with the minimum staffing complement. There were a number of staff on the team who had not been involved in a fire drill in 2022. Twenty-two out of a team of 36 staff members had not completed any planned evacuations. While some additional staff had been involved in unplanned evacuations in the centre, there was a need to improve oversight of drills and ensure that all staff had the opportunity to participate. The documentation of fire drills required improvement to include the scenarios used and the location of residents at the beginning of the drill.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need document was completed on an annual basis and this was completed by the person in charge. Residents were assigned key workers who met with residents on a monthly basis and reviewed their personal goals and progress towards these goals. There was evidence of residents engaging in activities which they enjoyed regularly both in and outside of the centre. However, the inspector did not find evidence that comprehensive assessments of need were carried out by or with appropriate health and social care professionals, that the review of the plan was multidisciplinary or that there was measures in place to ensure that the effectiveness of the plan was measured. There was also a need

to ensure that the needs identified in the assessment of need had corresponding care plans in place and that the information in the assessment was relevant to the current period of time.

Judgment: Not compliant

Regulation 6: Health care

Residents in the centre presented with complex health and social care needs. The inspector reviewed a sample of residents' care plans and found that residents were supported to have best possible health. They had regular access to a GP, psychologist, behaviour specialist and psychiatrist. Some residents had accessed a dietitian where it was required. However, some residents, had not had an up-to-date assessment carried out by a health and social care professional where they had an identified need in their health care plan. For example, for one resident, there was a need to ensure that they received a review by a relevant health and social care professional in line with their previous appointment in a timely manner. Another resident had a health action plan in place for a condition they had a number of years prior and this need was not identified in their assessment of need. For another resident, there were measures listed in an assessment of need, risk assessment and health care management plan which differed. This meant that there was not clear guidance for staff to follow to best meet the residents' assessed needs.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

As stated previously, residents in the centre had complex health and behaviour support needs. All residents had access to a behaviour specialist, a psychologist and a psychiatrist. All residents had a multi-element behaviour support plan in place which included PRN protocols for residents who required them. Staff had received training in multi element positive behaviour support and in verbal and safety interventions to use when supporting residents.

There were a high level of restrictions in place, with some residents living in very restrictive environments in line with their assessed needs. The Authority was notified of an increase in restrictive practices in quarter 3 of 2022. The inspector found that these restrictions had been assessed and were reviewed regularly, including reviews with residents to ensure that their wishes were documented to reduce restraints where possible. Where restraints such as physical holds or PRN was used, there were quality and safeguarding measures in place to ensure that these were used appropriately and this information was escalated to the multidisciplinary team or

management where required.

Judgment: Compliant

Regulation 8: Protection

The provider had a number of policies, risk assessments and procedures in place to safeguard residents from all forms of abuse. There had been a high number of allegations of abuse submitted to the Authority in the past 18 months. A provider assurance report had been sought was sought in 2021 and gave satisfactory assurances on the measures which the provider was taking to continue to monitor these allegations and ensure that they were reported in line with national policy. The inspector found that allegations in the centre had been reported, documented and investigated in line with national policy. Where required, safeguarding plans were put in place. Documented discussions took place with residents following any allegations or incidents and education had been completed with residents in relation to safeguarding. Residents were offered the complaints process where it was appropriate to do so. A sample of personal care plans were viewed by the inspector and found to be adequately detailed to guide staff practice.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Broadleaf Manor OSV-0003397

Inspection ID: MON-0032499

Date of inspection: 14/11/2022

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. The Person in Charge (PIC) shall conduct a review all residents documentation records and ensure all records and documentation are filed appropriately. 2. The PIC will ensure all records and documentations are maintained to a high standard with regular checks conducted by the Centre's administrator. 3. The above points will be discussed with the staff team at the next monthly staff team meeting.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Person in Charge (PIC) will conduct a review of all actions generated as part of the Centre's quality improvement initiatives, ensuring all actions are SMART and relevant to the findings of previous audits and closed out within agreed timeframes, where required. 2. Following the next scheduled audits, the PIC will ensure all actions are SMART and relevant to the findings of previous audits and closed out within agreed timeframes, where required. 3. The Centre's administration team, will ensure to monitor progress on all actions and update the PIC on a weekly basis and in turn update the Director of Operations, where required 4. The PIC will ensure, where actions are arising from the Centre's quality improvement initiatives, a weekly update is provided to the Director of Operations on actions that are closed. 5. Where required, the Director of Operations will conduct a periodic review of agreed	

actions closed linked to the Centre's quality improvement initiatives, reviewing the evidence provided by the PIC.

6. The above points will be discussed with the staff team at the next monthly staff team meeting.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The Person in Charge (PIC) shall conduct a full review of the Centre's premises daily to ensure all maintenance tasks are identified and are assigned to the Centre's maintenance team and where required, timeframe of works agreed for priority tasks.

2. The PIC shall conduct a review of all bathrooms daily in the Centre, to ensure they are maintained to high standard of hygiene and cleanliness. Any findings are assigned to the relevant staff member for address.

3. The PIC shall provide a weekly update to the Director of Operations on the Centre relating to the premises and any progress on priority maintenance works, where required.

4. The PIC will provide the Director of Operations a monthly update within the Centre's assurance report with the regard to hygiene, infection control and standard precaution practices, within the Centre.

5. Where required, the Director of Operations will conduct a periodic review of agreed actions closed linked to the Centre's quality improvement initiatives, reviewing the evidence provided by the PIC.

6. The above points will be discussed with the staff team at the next monthly staff team meeting.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The Person in Charge (PIC) shall conduct a review of all Service Users risk management plans to ensure that all risks relating to them are consistent with their care plans and updated where required.

2. The PIC shall conduct a review of the Centre's risk register to ensure all risks pertaining to the quality and safety of the Centre is identified and updated where required.
Note: Amendments to the Centre's risk register shall include additional assessments relating to IPC risks such as the management of linen and managing body fluid spillages.

3. The Director of Operations shall review the updated Service User risk management plans and Centre's risk register, in conjunction with the PIC to ensure all risks are identified and capture the needs of all Service Users and ensuring that the risks identified in the Centre's risk register are relevant to the quality and safety of the service and all controls are appropriate and proportionate to managing the identified risks.

4. Any updated risk management plans or risk registers shall be presented to the staff team and briefed on the risks identified and the relevant controls in place.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. The Centre's Infection, Prevention and Control Policy, shall undertake a review by Nua's Infection, Prevention, and control team. If applicable, the updated policy and procedure shall be reviewed and approved by Nua's Quality and Safety Committee and shared with the Person in Charge (PIC) to implement with their staff team, where required.

2. The PIC shall conduct a review of HIQA's preparedness and contingency planning and self-assessment for COVID-19 to ensure areas such as cleanliness and hygiene are identified as IPC risks and appropriate controls in place regarding cleaning and disinfection practices, ensuring the premises is maintained to an adequate standard daily.

3. The PIC shall brief the staff team of any updates to the Centre's quality improvement plan, following the review of HIQA's preparedness and contingency planning and self-assessment for COVID-19 tool.

4. The PIC will provide the Director of Operations a monthly update within the Centre's assurance report with the regard to hygiene, infection control and standard precaution practices, within the Centre.

5. Where required, the Director of Operations will conduct a periodic review of agreed actions closed linked to the Centre's quality improvement initiatives, reviewing the evidence provided by the PIC.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The Person in Charge (PIC) shall conduct a review of the Centre's fire drill schedule to ensure,
a) All staff members are scheduled to participate in a fire drill, where required.
b) Each planned fire drill clearly identifies the type of scenario to be used.

2. The PIC shall ensure that where any fire drill is completed (planned or unplanned) documentation should clearly identify, location of Service Users at the time of the drill and any learnings identified with an action plan in place.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. The Person in Charge (PIC) shall conduct a review of all Service Users Comprehensive Needs Assessments (CNA) in relation to the need (or not as the case may be), for multidisciplinary team (MDT).

2. Should MDT inputs be required, the updated CNA will include an associated confirmation sign-off from their discipline's perspective on the assessment and / or review of assessment.

3. The PIC will ensure, any updates of the Service Users CNA's shall be reflective within the Service Users Personal Plans

4. The staff team will be briefed at the next monthly staff team meeting by the PIC on the updated CNA and Personal Plan, to include:
a) The potential need for / verification from MDT members of agreement / review of assessment and:
b) The associated supports for safety and developmental needs of individual Service Users.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. As part of the overall review of the Service Users assessed needs, the Person in Charge (PIC) shall conduct a review of all Service Users health needs, in conjunction with their Multi-Disciplinary Team and Allied Health Professionals, where required.

2. Following the review of Service Users health needs, all relevant documentation and associated health management plans will be updated to incorporate any recommendations, where required.

3. The staff team will be briefed at the next monthly staff team meeting by the PIC on the continual attention on the Service Users health needs and implementation of associated health management plans.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	20/01/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/12/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	19/12/2022
Regulation 23(1)(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	20/01/2023

	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.			
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	20/01/2023
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 associated infections published by the Authority.	Not Compliant	Orange	20/01/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety	Substantially Compliant	Yellow	30/12/2022

	management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/12/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/12/2022
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is	Substantially Compliant	Yellow	30/12/2022

	the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/12/2022
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	30/12/2022