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

Issued by the Chief Inspector

Name of designated centre:	Cuan Mhic Giolla Bhride
Name of provider:	Inspire Wellbeing Company Limited by Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	17 November 2021
Centre ID:	OSV-0005559
Fieldwork ID:	MON-0034487

About the designated centre

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

This service can provide full-time residential care and support for two adults with disabilities. The centre consists of a modern, five bedroom, two storey house situated in a peaceful, scenic and rural setting in Co. Louth. It is within driving distance to a nearby city and a number of large urban towns. There are good sized grounds and well maintained gardens surrounding the centre and ample space provided for private car parking. The ground floor of the property is essentially divided into two separate living spaces for two of the residents who live on the ground floor of the property. Those residents have their own bedroom, bathroom and communal area one of which is sensory room and one is a sitting room. There is a well equipped kitchen with a breakfast bar, a dining room and separate laundry facility also. Upstairs there are two other bedrooms which are presently vacant, a staff room and an office. There is a full time experienced person in charge working in the centre. The centre is staffed on a 24/7 basis by team leaders, nursing staff and a team of support staff. Arrangements are in place to meet the needs of the residents, including as required access to GP services, allied health professionals and residents choose for themselves how to spend their day and what social/learning activities to engage in.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 17 November 2021	09:30hrs to 19:00hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the governance and management systems and the staffing arrangements had improved since the last inspection. Notwithstanding, improvements were still required in a number of the regulations inspected as discussed in Section 1 and 2 of this report.

On arrival to the centre, both residents were up and were being supported by staff to prepare for the day ahead. One of the residents, had been feeling a bit unwell the night before and was planning to relax for the day. The other resident went for a drive and a walk with the support of staff. This was really positive as the resident had not engaged in any outings over the last number of months. It was evident that the staff were really happy that the resident had agreed to go on this drive and the staff reported that the resident really enjoyed it.

There was adequate staff on duty at the time of the inspection. Staff were observed treating residents respectfully. Of the staff met they were familiar with the residents needs. They spoke positively about some training that had been provided to them by an occupational therapist to support one resident. They informed the inspector that this training had positively impacted to the resident as they had implemented some of the techniques learned that morning and the resident had engaged in the drive (as mentioned above).

One resident was observed relaxing in their room for the vast majority of the day, they had been feeling unwell and appeared content watching their computer. Their bedroom was spacious, had a large double bed with adequate storage. Some nice sensory lights were in the room, which the resident was reported to like.Staff informed the inspector that the resident had secured a day placement and was waiting to start this in the new year.

The other resident was in the process of being assessed by an occupational therapist and a speech and language therapist. It was envisaged that the review and recommendations from this would enable a more structured day and other improvements to the quality of life for the resident.

The team leader on duty ensured the inspector followed the health surveillance checklists in relation to COVID-19 before allowing them to enter the premises. Staff were observed wearing personal protective equipment on the day in line with the tasks they were doing and the needs of the residents.

The centre was generally clean, and each resident had their own bedroom. However, some actions from the providers own audits had not been completed in relation to the premises.

The improvements required to this and other regulations inspected are discussed further Section 1; Capacity and Capability and under Section 2; Quality and Safety of

this report.

Capacity and capability

Overall, while the inspector found that the provider made improvements to the governance and management arrangements in the centre and had been actively recruiting permanent staff to work in the centre since the last inspection; improvements were still required going forward. This was to ensure that a consistent staff team was employed in the centre, that improvements identified from the providers own audits were addressed in a timely manner. Significant improvements were still required under staffing, governance and management, records stored and personal plans. While some improvements were still required in the premises, positive behaviour support, infection control, staff training and risk management.

This centre was inspected on 16 September 2021, where significant failings had been identified in most of the regulations inspected. The governance and management and the staffing arrangements were not adequate at that time to ensure effective oversight of the centre or to ensure consistency of care to the residents. Following this inspection the provider attended a warning meeting to discuss the findings. A warning letter was issued to the provider requesting them to come into compliance with the regulations by the 16 November 2021.

At this inspection the inspector found that the provider had addressed or was in the process of addressing the non compliance's identified at the last inspection. Some of the actions had not been completed to assure compliance with the regulations as the providers timeframes were either unrealistic or the time lines had not been reached from the compliance plan submitted. This meant that improvements were still required.

Since the last inspection improvements had been made to the oversight arrangements in the centre. The assistant director of care and support who was previously a person participating in the management of the centre was now employed in the role of the person in charge. They spent four days a week in the centre. The provider had also redeployed three team leaders from other areas of the organisation who each worked two days a week in the centre. This meant that there was increased oversight of the care and support being provided in the centre.

The provider had also conducted a number of audits since the last inspection called service improvement plans. The inspector followed up on a number of actions from these and found that while some had brought about improvements to the quality and safety of care being provided, some of the actions had not been completed. For example; monthly summary reports were due to be completed for residents and they were not done, staff were to start labelling food in the fridge and this was not being done, additional training recommended for staff on hand hygiene and donning and doffing personal protective equipment (PPE) was not completed. This required

improvements.

There was a planned and actual rota in the centre. Rosters were now planned in advance every four weeks to ensure that staff knew the hours they would be required to work and to arrange consistent agency/relief staff to be employed. A review of a sample of these records since the last inspection found that the person in charges hours were now included on the staff rota. A review of the roster over the last number of weeks found that nurses were employed continuously in the centre in line with the statement of purpose for the centre and sufficient staff were employed each day. These issues had been identified at the last inspection.

The nursing staff employed who were all agency staff were now block booked from the agency provider. They were employed on a sleepover basis meaning that the residents had access to a nurse should the need arise on a 24/7 basis and as the agency staff worked in the centre on a full time basis, they were able to provide consistency of care while the provider was recruiting full time staff. The provider had also appointed one permanent support worker, who had just taken up employment. A nurse, a team leader and six support workers had also been offered and accepted positions in this centre. Those staff were still awaiting clearance to take up employment. Notwithstanding, the improvements made the provider was still aware that more needed to be done to ensure that a full time consistent team were employed in the centre and from the compliance plan submitted following the last inspection intended to reach this target by 30 Jan 2022. For example; at the time of the inspection a further 1.3 whole time equivalent fulltime nurses needed to be recruited, 1.44 team leaders and 4.15 support workers still needed to be recruited.

The inspector also reviewed a sample of staff personnel files to ensure that staff had up to date Garda vetting in place. This had been a concern at the last inspection. The provider had submitted assurances to the Health Information and Quality Authority (HIQA) following the last inspection to verify that all agency staff were Garda vetted. A sample of ten agency staff files reviewed, verified that Garda vetting had been confirmed from the agency provider. One permanent staff file was reviewed also, while this contained all the records required under the regulations and the person in charge confirmed they had reviewed this record with the HR department, the record was not available on the day of the inspection, however assurances were provided after the inspection.

Since the last inspection the provider had reviewed the staff contingency plan in the event of a shortfall of staff in the centre. This included redeploying staff from the day service, other designated centres under this provider, linking with agency providers or the funding body to seek additional staff resources.

Following the providers compliance response from the last inspection, they had indicated that they intended to review the roster and strive towards a more social led model of care where nurses would not be part of the staff team. The person in charge indicated that this had been reviewed subsequently and it had been agreed that moving to this model of care was not being considered at the moment and nursing staff would remain in order to meet the needs of the residents. This meant

that all staff employed were no longer required to have training to support a resident to administer a peg feed.

A sample of training records were reviewed. At the time of the last inspection, it could not be verified if all of the agency staff employed in the centre had up to date training (including refresher training) to ensure they had the necessary skills to support the residents in the centre. The inspector reviewed a sample of the records and found that agency staff had training which included; infection control, safeguarding, fire safety, manual handling and first aid. The staff training for the permanent staff indicated that they had been provided with training in management of actual or potential aggression (MAPA), fire safety, infection control, safeguarding vulnerable adults and first aid. The provider had training booked for staff to have bespoke professional management of aggression and violence (PMAV) training in November and December 2021. In addition, there was some confusion with staff members about the training they were required to have when supporting a resident with some of their support needs. This had been reviewed but needed to be formally addressed and included in the residents' support plans and risk assessments.

The provider had also indicated from an audit conducted that staff required refresher training in hand hygiene and donning and doffing of personal protective equipment (PPE).

Staff met with said they felt supported in their role. A sample of supervision records found that this had been completed recently with a team leader. Staff were able to raise concerns at this meeting and staff meetings were held to discuss the care and support of residents. All new staff who started work in the centre had induction completed with them. This included a comprehensive list of things they needed to be aware of when working in the centre.

At the time of the last inspection it was found that the records stored in the centre were not accessible and were not up to date. The inspector found that some records had been updated. However, significant work was required to ensure that the records were accurate and streamlined. For example; there was eight files/folders presented to the inspector containing one residents personal care and support records. Some contained information that was up to date and some contained older records. Which posed a potential risk to residents in that the most appropriate care may not be delivered if there is conflicting information.

The person in charge acknowledged this, demonstrated that they were committed and knew the improvements required to meet the requirements and ensure that records were accurate. Therefore at the time inspection this regulation remained not compliant and warranted further improvements.

The Garda vetting records for one staff were also not available in the centre on the day of the inspection.

There had been not complaints in the centre since the last inspection.

Regulation 15: Staffing

The staff rota in the centre now included the person in charges hours worked.

From a review of a sample of rotas, there was sufficient staff on duty each day to meet the needs of the residents. Out of hours on call arrangements was provided by senior managers.

At the time of the inspection a further 1.3 whole time equivalent nurse's, 1.44 team leaders and 4.15 support workers still needed to be recruited. This meant that there was still an over reliance on agency staff in the centre, and the provider was aware of their responsibility to address this.

Judgment: Not compliant

Regulation 16: Training and staff development

At the time of the inspection some of the training was still outstanding for the staff. The provider had indicated in their compliance plan that this would be completed by 14 December 2021.

Refresher training in hand hygiene and donning and doffing PPE had not been completed at the time of the inspection.

The person in charge stated that there had been some confusion with staff members about the training they were required to have when supporting a resident with some of their support needs. This had been reviewed but needed to be formally addressed and included in the residents' support plans and risk assessments.

Judgment: Substantially compliant

Regulation 21: Records

At the time of the last inspection it was found that the records stored in the centre were not accessible and were not up to date. The inspector found that some records had been updated. However, significant work was required to ensure that the records were accurate and streamlined.

The person in charge acknowledged this, therefore at the time inspection this regulation remained not compliant and warranted further improvements. The person in charge however demonstrated that they were committed and knew the improvements required to meet the requirements and ensure that records were

accurate.

The Garda vetting records for one staff were not available in the centre on the day of the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre had significantly improved however, findings from audits were not always been implemented.

In addition, given that a number of actions were still outstanding at this inspection, improvements were still required going forward to ensure that the centre was adequately resourced.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose had been reviewed and updated to reflect the changes in the management structures and the number of staff employed in the centre which included the provision of nursing care on a 24/7 basis.

Judgment: Compliant

Regulation 31: Notification of incidents

No incidents had occurred in the centre since the last inspection. The provider had followed up on the actions from the last inspection.

Judgment: Compliant

Quality and safety

Overall, the inspector observed a number of improvements since the last inspection which were contributing to improving the quality of life of the residents. However, as

mentioned earlier in this report the premises, personal plans, positive behaviour support, risk management, infection control and safeguarding required improvements.

At the last inspection a number of improvements had been required to the premises. The provider had committed to completing this work by the time of the inspection. The inspector found that given the needs of the residents in the centre, that this time frame was not realistic and consequently a number of issues still needed to be addressed. However, the inspector was satisfied that they were due to be addressed. The person in charge outlined a number of actions that were due to take place to the premises. This included; new flooring throughout the downstairs area; all areas in the centre to be painted; new soap dispensers were ordered and perspex panels to surround the soap dispensers to allow for easy cleaning; a new chair for one resident was due for delivery; some kitchen cupboards needed to be fixed; the wiring for one fire door needed to be fixed and the outside area for one resident was being reviewed to ensure that this area was safe and comfortable for the resident to use.

Due to one residents' needs, their living area including the walls in the bedroom, shower, dining area and sensory room had soft padding applied to prevent injury to the resident. The living area for the resident was small and confined, however, this was continually reviewed by the multi-disciplinary team and was a recommendation due to their assessed needs. Since the last inspection one resident was reviewed by an occupational therapist; part of this review included assessing the residents living environment including the sensory room in the centre. This review was still ongoing at the time of this inspection. This would address the residents accessibility in the centre which was an issue at the last inspection.

There were no records to indicate whether some equipment used in the centre was maintained in good working order. For example; a transport harness used for one resident.

Residents had personal plans in place however, as already mentioned under records, improvements were required. The assessment of need in place for residents had not been updated at least annually or when the residents' needs changed. While their were plans in place to guide how residents were supported with their health care needs, there were no plans in place around how residents social care needs were been supported. For example; residents did not have any goals set that they may wish to achieve. Some of the easy read plans for residents were also not reflective of their actual needs. For example, it stated that one resident may be supported to prepare meals in the centre however, this was not in line with their assessed needs.

At time of this inspection, residents were supported with their health care needs and had timely access to allied health supports. The care and support of the residents was reviewed annually or in some circumstances monthly by allied health care professionals. Since the last inspection, both residents now had the support of a speech and language therapist. One resident had been reviewed and recommendations had been made to support the resident which were also being

reviewed with the wider multi-disciplinary team at the time of the inspection.

The other resident had met the speech and language therapist informally and was awaiting a review to support them with their specific communication styles. One resident had a sensory assessment completed with an occupational therapist who had made a number of recommendations regarding the residents care. Their report was not ready on the day of the inspection, however, the person in charge outlined some of them which included, creating a structured routine for the resident. Sensory integration training had also been provided to staff. Staff who spoke to the inspector said that this was very informative. On the day of the inspection staff were observed implementing some of the learning from this training.

Residents received to support manage their mental health. Where required residents had access to support of from a clinic nurse specialist in behaviour, psychologist and psychiatrist. A positive behaviour support plan was in place to guide practice. Some of the interventions in the support plan required the use of restrictive practices as a last resort. However, the inspector found that the interventions in place needed review to ensure that they adequately guided the practices in the centre and they needed to be signed by the professionals prescribing them. A restrictive practice log was maintained in the centre and restrictive practices were also reviewed with members of the allied health team and the residents advocate.

The provider had systems in place to manage risks in the centre. This included a risk register and individual risk assessments for residents. Incidents were reviewed at staff meetings when they occurred in the centre. However, one risk relating to fire had not been risk assessed. The person in charge had conducted a risk assessment prior to the end of the inspection. Staff spoken to were aware that the fire door should remain closed at all times in the centre.

Staff had been provided with training in safeguarding vulnerable adults. Of the staff met with, they were aware of when and how to report a safeguarding concern should one occur in the centre. The actions from the last inspection had been addressed. Residents had intimate care plans in place to guide staff practice. One residents intimate care plan needed to be reviewed to ensure that they provided consistent guidance in relation to physical holds used to support the resident.

The were systems in place to manage an outbreak of COVID-19 in the centre. Staff had been provided with training and were observed wearing face masks and PPE during the inspection. There was sanitising gels available at entry points and signage relating to hand washing techniques. An environmental audit had been conducted which had identified some areas to improve. This included, refresher training for staff in hand hygiene and sourcing pedal bins in some areas. These actions had not been fully completed at the time of the inspection.

Regulation 17: Premises

The person in charge outlined a number of improvements that were due to take

place to the premises which were not completed at the time of the inspection. This included;

- new flooring throughout the downstairs area
- all areas in the centre to be painted
- new soap dispensers ordered and perspex panels to surround the soap dispensers to allow for easy cleaning
- new chair for the resident was due for delivery
- the outside area for one resident would be reviewed to ensure that this area was safe and comfortable for the resident to use
- wiring for one fire door needed to be fixed
- some kitchen cupboards needed to be fixed.
- there were no records to indicate whether some equipment used in the centre was maintained in good working order. For example; a transport harness used for one resident.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

One risk relating to fire safety had not been risk assessed one the day of the inspection to outline the controls in place to mitigate the risk.

Judgment: Substantially compliant

Regulation 27: Protection against infection

An environmental audit had been conducted which had identified some areas to improve. This included, refresher training for staff in hand hygiene and sourcing pedal bins in some areas. These actions had not been fully completed at the time of the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was no comprehensive assessment of need in place for residents that had been updated at least annually.

While their were plans in place to guide how residents were supported with their health care needs, there were no plans in place around how residents social care

needs were been supported. For example; residents did not have any goals set that they may wish to achieve.

Some of the easy read plans for residents was not reflective of their actual needs. For example, it stated that one resident may be supported to prepare meals in the centre, however this was not in line with their assessed needs.

Judgment: Not compliant

Regulation 6: Health care

At time of this inspection and since the last inspection, residents were supported with their health care needs and had timely access to allied health supports. The care and support of the residents was reviewed annually or in some circumstances monthly by allied health care professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Some of the interventions in the support plan which required the use of restrictive practices as a last resort, needed review to ensure that they adequately guided the practices in the centre and were signed by the professionals prescribing them.

Judgment: Substantially compliant

Regulation 8: Protection

Following the last inspection, the person in charge had initiated and put in place an investigation in relation to this incident to establish if the resident had suffered harm. This had been completed and no safeguarding concerns had been identified.

One residents intimate care plans needed to be reviewed to ensure that it provided consistent guidance in relation to the holds used.

Judgment: Substantially 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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Cuan Mhic Giolla Bhride OSV-0005559

Inspection ID: MON-0034487

Date of inspection: 17/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Recruitment campaigns continue to run every 2 weeks continually. 2 candidates have been interviewed thus far for the role of PIC, 1 candidate was successful, but has since declined the offer of employment, this post has been re-advertised. There is 1 x Nurse (24 hours per week) with a confirmed start date of 28.12.2021. There is 1 x 36 hour Team Leader currently going through pre-employment checks. There are 4 Support Workers (3 x 25 hours per week, 1 x 37.5 hours per week) currently going through pre-employment checks. Start dates for all candidates will be confirmed by 31.01.2021. Since our last inspection we have appointed 2 x Inspire Relief Support Workers into permanent Support Worker roles, 2 x 12.5 hours per week. Current vacancies are as follows: Nurse 2.29, Team Leader 2.44, Support Worker 7.48, and (all WTE). There are 3 Inspire Team Leaders currently seconded into Cuan Mhic Giolla Bhride 2 x days per week each, which has been in place since September 2021, this arrangement will remain in place to support the Service until there are permanent staff recruited. PPIM has taken up the role of PIC since 01.09.2021, this arrangement will remain in place until a permanent PIC is recruited. All Agency staff in Cuan Mhic Giolla Bhride are working consistently in the Service, on a block booking arrangement. There are protocols in place with all Recruitment Agencies that the Service is in partnership with, whereby Agency staff are booked into 1 centre only, and are not permitted to work across multiple centers at any time. These protocols promote high standards of infection control, as well as continuity of service. The vacant posts once all new staff take up their new roles will be as follows: Nurse 1.65, Team Leader 1.44, PIC 1, and Support Worker 4.48 (all WTE). Inspire will remain fully committed to the recruitment and retention of a full staff team in Cuan Mhic Ghiolla Bhride.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All Inspire staff and all Agency staff working in Cuan Mhic Giolla Bhride have completed the full suite of Infection Control training modules on HSE Land. PMAV training was facilitated for all Inspire staff and Agency staff on Friday 26th November 2021 and Friday 3rd December 2021, a total of 20 staff were in attendance. Further sessions are to be arranged for the new year for the practical training elements of PMAV to be delivered to staff, this was not facilitated at this time due to COVID-19. MAPA training for the 4 staff who required it was facilitated on 16.12.2021. All other mandatory training was 100% compliant on the day of the inspection and remains at 100% compliant. 1 agency staff did not have an up to date infection control training certificate on the day of the inspection, this staff member has not been working shifts within Cuan Mhic Giolla Bhride, PIC has confirmed with the Recruitment Agency that this staff member has not been booked in for any shifts, and will not be booked in for work until their training certificates have been submitted. This staff member has since completed the infection control training and has commenced working shifts again in Cuan Mhic Giolla Bhride. Sensory Integration training was facilitated for 17 staff members on 11th and 12th November 2021. There will be Speech and Language bespoke training delivered to the staff team in the new year when the new staff have taken up their roles. Care plans have been updated to include the training requirements of staff supporting CMGB4 with personal care and feeding tasks, as well as supporting this individual with clinical holds.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
There is a process in place whereby the PIC views and verifies the Gardai Vetting certificate of all staff as part of their pre-employment checks prior to them taking up their role. This process is done via Microsoft Teams video call. The reference number of the Gardai Vetting certificate and the date received, as well as the date reviewed by the PIC is signed and recorded within individual staff personnel files. Gardai Vetting certificates are not kept on file in the Service, these records are stored centrally within the Inspire HR Department. Gardaí Vetting Certificates can be reviewed at any time via Microsoft Team during inspections, or for any other reason, a member of the Inspire HR Department can facilitate this. Care plans for both Residents are under review, work is underway to remodel the current templates and formats of all of the information and guidance the Service is holding for the Care and Support for both Residents. The new templates will provide all information about the Care and Support for both information in a much more concise and streamlined manner, with a clear link across all aspects of their life including their mental health, physical health, social and communication needs. The newly revised Care Plans will be completed by 31.01.2022. In the interim period, the current care plans are available, and contain the most up to date information and

guidance about both Residents. There has been extensive work on the current recording systems used within Cuan Mhic Giolla Bhride, for all aspects of daily operational tasks, these systems are also under further review, to be remodeled to be more concise and streamlined. These updates will be completed by 31.01.2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There has been a significant number of actions completed in the Service from all audits carried out in relation to the environment, health and safety. Further information has been sought regarding the maintenance/servicing of a safety harness for the scheme vehicle for 1 Resident. Since the inspection a replacement harness has been sourced and purchased, we are awaiting delivery. Clarity has been sought from the manufacturer and supplier of the harness, the equipment does not require servicing. A list of observations and visual checks have been recommended by the supplier that will be carried out as part of the routine vehicle for good practice. The scheme vehicle has been taxed and is fully up to date. The central heating boiler is scheduled to be serviced in December. This is our only outstanding action from our audits presently.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The downstairs flooring has been assessed by the landlord, all areas of the flooring with damage/cracks etc have been fixed, resealed and freshly varnished. The hallway, staircase, dining room, kitchen, utility, office, and toilet have been repainted, woodwork downstairs has been sanded and varnished, and the stair case has been sanded and varnished. Wall mounted soap dispensers, and hand towel dispensers have been installed. New leather recliner chair has been fitted to the floor for CMGB4. Bracket closure mechanism for the entry door into CMGB4's apartment has been replaced. New kickboards have been fitted in the kitchen. Crack on one kitchen cupboard has been repaired. Paint work has just recently finished, we are only awaiting the installation of Perspex wall panels for the hand sanitising stations throughout the building. New replacement transport harness has been sourced and purchased for CMGB4, awaiting delivery at this time. Current harness remains fit for purpose for CMGB4, the material, fixtures and fitting remain fully intact and in full working order, there are no signs of any ware and tare, there are no details available as to where the current harness was purchased, for the Service to be able to make contact in the event we needed a

replacement part or component etc, so a decision was made to replace the harness. The outside area has been discussed with the MDT and Sensory OT. Further assessments are to take place in the New Year regarding the long term plans for the outside environment, with work to commence thereafter, this will be a long term goal for the MDT. In the interim period CMGB4 will continue to be supported on a 4:1 staffing ratio at all times when outside of his home to ensure his health and safety.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The workplace risk assessment was updated on the day of the inspection with regards to 1 x bracket closure mechanism being broken in the entry door to CMGB4's apartment, risk management strategies in place to ensure this door is kept shut at all times. New mechanism was fitted 2 days later on 19th November 2021. Workplace risk assessment has been updated to reflect this.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
All staff have completed HSE Land Infection Control suite of modules. There are 2 new pedal bins purchased for the kitchen. Wall mounted soap dispensers and hand towel dispensers are 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:
PIC has developed a new Comprehensive Assessment of Need template and completed same for both Residents, which is dated, and will be reviewed every 6 months or as

required as per the Residents changing needs. Care plans and are being reviewed and updated at this time, to be completed by 31.01.2021. Easy read documents for both Service Users have been reviewed and updated and are accurate and reflective of both Service Users needs at this time.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
PIC has developed an up to date Positive Behaviour Support plan which is underpinned by the professional guidance and information that is already in place and available. Support plan identifies specific strategies for staff to implement in the event that a Resident becomes distressed and requires staff support. Positive Behaviour Support Plan is currently being reviewed by the Positive Behaviour Support Practitioner along with the PIC for final sign off. Positive Behaviour Support Practitioner carries out a monthly progress review for both Residents, and provides a report for same, progress reports continue to be shared and discussed each month for one Resident at the MDT meeting.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Intimate Care Plans have been reviewed and updated fully and are accurate with the information and guidance required to provide the correct care and support to one Resident to meet his intimate care needs. These care plans are up to date and will remain in place whilst a further, wider remodeling of all care plans is ongoing and new templates and formats are developed and completed.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/09/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/09/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	16/12/2021

	training, including refresher training, as part of a continuous professional development programme.			
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	31/12/2022
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	16/12/2021
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in	Substantially Compliant	Yellow	31/01/2022

	Schedule 2 are maintained and are available for inspection by the chief inspector.			
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.	Not Compliant	Orange	31/01/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2021
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	19/11/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a	Substantially Compliant	Yellow	16/12/2021

	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.			
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	16/12/2021
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal development in accordance with	Not Compliant	Orange	31/01/2022

	his or her wishes.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31/01/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	15/01/2022
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	16/12/2021