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:	Baldoyle Residential Services
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	20 October 2021
Centre ID:	OSV-0002340
Fieldwork ID:	MON-0034325

About the designated centre

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

The centre is located in a seaside residential suburb of Co. Dublin and is located on the first floor of a large three storey building. The ground floor of this building comprises a primary school for children with disabilities, a day care facility for adults and a swimming pool. Administration offices are located on the second floor where outpatient clinics are also held. Access to the designated centre is through a large reception area for the entire building and there is a lift and stairs available to residents. The entire property is owned by St. Michael's House (SMH). The designated centre is divided into two areas, each with their own living areas and kitchen facilities. Eleven residents reside in the centre. Residents are supported by a team of nurses and care staff. The centre is closed to admissions from external agencies as it is classified as a congregated setting. The provider proposes to de-congregate the centre in line with national policy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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 20 October 2021	09:10hrs to 17:50hrs	Amy McGrath	Lead
Wednesday 20 October 2021	09:10hrs to 17:50hrs	Ciara McShane	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was carried out to assess the implementation of actions required from the previous inspection and to monitor compliance with the regulations. There were eleven residents living in the centre at the time of inspection, with five vacancies. The inspectors met with 10 residents; some residents in this centre used non-verbal communication as their primary communication method, and so residents greeted inspectors but did not speak with them. The inspectors spoke with staff, observed care and support practices throughout the day and reviewed documents in order to form a judgement on the experience of residents.

Baldoyle Residential Services is located in a large three storey building in North Dublin. The designated centre is located on the first floor of the building. There is a school and day service facility on the ground floor with clinic services provided on the second floor. The inspectors carried out a walk-through of the premises which had undergone substantial works since the previous inspection, with some ongoing building works underway at the time of inspection. These works were undertaken in response to the previous inspection in order to address fire safety risks and non-compliance with regard to premises and infection control.

Residents each had their own bedroom, however at the time of inspection two residents were temporarily sharing one large room while fire safety upgrades were being made to the corridor on which their own bedrooms were located. Residents' bedrooms were seen to be spacious and decorated in accordance with their preferences. There were two large living areas available for residents' use which were observed to be clean and tidy with seasonal decorations. There were two small kitchens in the premises, which contained breakfast foods and snacks, and each had an attached dining area. Residents' mains meals were prepared in the kitchen on the ground floor of the building and delivered to the centre twice per day. Both kitchen areas also contained a space for storage of medicines and records.

While the premises contained ample space and facilities, the design and layout was not effectively meeting the aims and objectives of the service given the number and needs of residents. The premises was separated into two zones, with women in one area and men in another. Generally, each zone had their own staff team with some crossover when required.

It was observed that residents spent a large portion of the day in the centre, with little planned activities or engagements. A number of residents spent most of the day (outside of meal times) watching television in a living area. One resident remained in their bedroom for the duration of the inspection, which appeared to be their own preference. Inspectors found that residents' daily routines were often led by staff. One resident, who required one to one nursing support, had spent the previous night sleeping in the living area as their nursing supports could not be provided in their bedroom overnight given the support needs of other residents. At

times, to ensure this residents' safety, they remained with the nurse on duty as they carried out other tasks and duties in the centre, which limited opportunities for leisure or recreation activities for the resident.

The centre was staffed by a team of nurses and healthcare assistants. There was a staff member who was responsible for housekeeping and cleaning in the centre. Communication between staff and residents was observed to be friendly and encouraging, although sometimes brief. Staff appeared to be knowledgeable of residents' care needs and spoke in detail to inspectors regarding residents' support plans. Inspectors observed some staff members using personal protective equipment (such as gloves) inappropriately, which presented an infection control risk.

A review of records found that while residents health and safety needs had been comprehensively assessed, there was very little information available regarding residents' social and personal needs and preferences. For example, for some residents, care plans indicated there were no preferences regarding how they dressed or were supported with intimate care. Inspectors found that care plans did not guide person centred practice. Some practices in the centre were found to limit residents' opportunities to make choices about how they spent their day.

Overall, while the provider had committed to addressing the safety issues found at the last inspection, significant change was required to ensure residents received a high quality service that met their individual holistic needs.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

The governance and management arrangements were not effective in ensuring residents received a safe and high quality service. The provider was addressing safety issues that were identified at the previous inspection, and it was found that the implementation of the compliance plan in relation to these issues was being carried out in accordance with the timelines submitted by the provider. Notwithstanding, the inspection found that deficits in the governance and management arrangements had contributed to poor quality care and support for residents. The oversight arrangements in place were not effective in identifying areas for improvement and it was found that the provider was not ensuring that residents received appropriate care that met their individual assessed needs.

There was a person in charge in the centre, who was a qualified professional with experience working in and managing services for people with disabilities. They were also found to be aware of their legal remit with regard to the regulations and were

responsive to the inspection process.

Residents were supported by a team of staff nurses and healthcare assistants, with a clinical nurse manager 1 (CNM1) who reported to the person in charge. While the provider had recently increased staffing at night in response to a fire safety risk, it was found that the staffing levels were insufficient to meet the needs of all residents. A review of daily notes, and discussions with staff, found that the centre was inadequately resourced to proactively plan and deliver care and support that met each individuals' health, personal and social care needs. It was not evident that the staffing arrangements were based on an assessment of residents' needs.

The inspectors reviewed the provider's arrangements to ensure that staff had the appropriate and required training completed. The person in charge maintained a training matrix which evidenced that some additional training had taken place since the last inspection, for example staff were trained in COVID-19 and had enhanced training in local fire procedures. However, there were a high number of training gaps that needed to be addressed including safeguarding, positive behaviour support, manual handling and first aid. It was found that staff were receiving supervision and attending staff meetings and recent records for each of these were reviewed.

The provider had carried out an annual review of the safety and quality of the service for 2020. Staff had contributed towards the review and shared the views of residents with regard to the service. Inspectors found the review did not assess the quality of care against the relevant standards, as outlined in the regulations and did not contain sufficient information as to inform learning or quality enhancement.

While there was a clear governance structure in place, it was not demonstrated that this was effective in escalating areas of risk to senior management. It was found that some quality deficits were known to staff and the person in charge and discussed at team meetings and supervision, however the reporting systems had not ensured that these concerns were escalated to an accountable person in the organisation and addressed in a timely manner.

The inspectors reviewed records related to the most recent admissions to the centre, and found that they had occurred in accordance with the statement of purpose and the provider's own policy.

Regulation 14: Persons in charge

The person in charge was employed in a full time capacity and had the necessary experience and qualifications to fulfil the role.

Judgment: Compliant

Regulation 15: Staffing

The provider had not ensured that staffing arrangements in place met the assessed needs of all residents. While nursing staff was available, the number of nurses was not sufficient to meet all residents' healthcare needs in a person centred manner.

Improvement was required to ensure that staffing arrangements were determined based on the assessed needs of all residents in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had availed of additional training since the previous inspection, however some training gaps remained. The person in charge had carried out a review of training and staff training deficits were known to the provider. In some cases staff were scheduled to attend relevant training.

Gaps in training included:

- 22 staff required First Aid training, all of which were scheduled.
- Five staff were required to complete the provider's online fire training.
- Five staff were required to complete Children's First training.
- Three staff were required to complete safeguarding training.
- Three staff required food safety training.
- Two staff required manual handling training.

Judgment: Not compliant

Regulation 23: Governance and management

While the provider had implemented the actions set out in the compliance plan from the previous inspection, further improvement was required with regard to the governance and management arrangements to ensure that the quality and safety of the service was consistently and effectively monitored.

There was evidence that reviews of quality and safety were carried out, however these were not effective in identifying key quality and safety risks. Furthermore, areas for quality improvement previously identified by the provider had not been addressed in a timely manner and residents had a suboptimal experience in areas such as welfare and development.

At the time of inspection, the provider had carried out a review of compliance with the regulations and developed a quality enhancement plan based on this review.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Admissions to the centre had been carried out in accordance with the provider's own policy and the admissions process considered the need to protect residents from abuse by their peers.

Judgment: Compliant

Quality and safety

The governance and management arrangements in the centre did not consistently support the provision of safe and quality care. While the provider had begun to address the safety issues identified at the previous inspection (discussed later in the report), the quality of care was negatively impacted by unsuitable accommodation, ineffective oversight, and institutional practices. The inspectors found that the provision of care was largely task-led, and did not uphold residents' individual rights, or adequately meet their health, social and personal needs.

The inspectors walked around the centre throughout the day of inspection and found that some improvements had taken place in line with the provider's compliance plan response, submitted subsequent to the last inspection. These included upgrade works to the kitchen, repairs to bathroom facilities, the replacement of two bathroom floors, lime scale was removed from a number of surfaces, a previously open down pipe was closed and the cleaning schedules for the centre were reviewed. However, further improvements were still required to the premises including repairs to flooring throughout the centre, painting of the centre, repairs to wallpaper, rust on radiators and addressing damaged surfaces and presence of mould in one bathroom, as they posed as an infection control risk.

The general design and layout was not suitable for the provision of person centred care in a homely environment. As stated previously, the centre was located on the first floor of a three storey building, and was entered through a shared reception on the ground floor. The layout of the premises was clinical in nature, despite efforts to decorate it in a homely manner. While there was plentiful space and storage facilities, the size and layout contributed to deficits in the provision of timely and person centred care. For example, due to the distance between residents' bedrooms staff could not supervise all residents in their own rooms when their healthcare

needs necessitated additional monitoring. On the morning of the inspection, a resident's bed had been moved to the living room to ensure their needs could be met overnight.

While the facilities outlined in Schedule 6 were provided (such as laundry and kitchen facilities) it was found that these weren't utilised in a manner that supported residents to engage in preparing or cooking meals, or managing their own laundry. Despite having the facilities to manage food and laundry in a more domestic manner, the majority of meals were prepared in the buildings main kitchen, and laundry was taken to the laundry service on the ground floor.

Inspectors found that residents had limited access to occupation or recreation facilities. Residents spent most of their day in the centre, with time spent at home increased over the past year due to the closure of day services in response to the COVID-19 pandemic. While there was evidence that residents would recommence day services as they reopened, the options available appeared to be based on resources and proximity to the centre rather than residents' individual interests, needs or abilities. For example, seven residents were due to return to the day service on the ground floor of the building the centre was located in. Inspectors found that these arrangements contributed to the isolation of residents, who had very minimal engagement with the wider community.

Residents were observed in their home watching television and listening to music, including listening to music playing on a keyboard. Activities in the centre were seen to be limited and were not planned in consideration of residents' individual abilities and developmental needs. The care planning arrangements in the centre did not support the personal development of residents. A review of residents' personal plans found that personal goals set for the year ahead were largely related to their basic physical or healthcare needs.

Inspectors reviewed records related to residents' finances. All residents received support to manage their finances. It was found that the system in place to support residents in managing their money did not facilitate residents to have ownership of their own finances. In some cases residents money was paid into an account with a second named account holder who was a previous employee in the organisation. The provider's own financial audits did not identify this as an issue. In cases were residents received support from a third party to manage their finances (outside of the organisation), it was found that the arrangements were not transparent and prevented residents from having ready access to their own money.

In one case a resident had less than 20 euro for more than five months, which significantly limited their ability to engage in leisure activities or buy personal items such as clothing or toiletries. Staff in the centre ensured that the resident had a supply of all basic hygiene products and attempted to include the resident in activities they could afford, however it was of concern that the resident did not have access to their money or opportunities to make choices about how they spent it. While this had been identified by the person in charge as a safeguarding risk, and escalated in line with the provider's safeguarding policy, there had been no progress made with regard to addressing the issue. Significant change was required to ensure

that residents' rights in relation their personal possessions were upheld.

Residents were provided with wholesome and nutritious food, although the arrangements for food preparation were institutional in nature with main meals being delivered from the building's central kitchen. While staff endeavoured to communicate residents' preferences with regard to the menu, this could not always be facilitated. Staff spoken with told inspectors that if residents didn't like the food that arrived, they would likely eat it anyway. This arrangement restricted residents' opportunities to make choices about what they ate. Since the previous inspection, one resident had started to do their own grocery shopping for preferred items, with staff support. However, for all other residents, there was very little, if any, opportunity to participate in the buying, preparation or cooking of their meals. The meals that were prepared for residents were prepared in consideration of residents' feeding and eating plans, for example in the case where food was to be modified based on a healthcare recommendation.

There were a range of safeguarding measures in place to protect residents from the risk of abuse. While it was noted that potential safeguarding risks were identified at a local level, not all incidents of a potential safeguarding nature were appropriately screened. There were plans in place to guide staff in the delivery of personal and intimate care. The inspectors were not satisfied that these plans contained sufficient information to support the delivery of care in an individualised manner.

Residents who required support to manage their behaviour had support plans in place that were developed by an appropriate professional. The person in charge had identified most of the restrictive practices in the centre, and had ensured that a risk assessment had been carried out to facilitate review of their suitability and use. While some staff had received training in positive behaviour support, at the time of inspection 12 staff members required further training.

There was a risk management policy and associated procedures in place. There was an accurate risk register in place that reflected the risks identified in the centre. The person in charge carried out planned reviews of incidents and accidents, and ensured that learning from incidents was discussed at team meetings.

The provider had made some improvements to infection control arrangements as per their compliance plan response. For example, enhanced audits were completed, premises works as outlined previous were completed, and staff repeated refresher COVID-19 training. Further enhancements were required, which as outlined under regulation 27, protection against infection. The inspectors acknowledge the provider had sought and secured funding for the painting and flooring works, however these would not be completed until the fire safety works were finished.

The provider had made improvements to fire safety and had completed a significant number of the actions following the last inspection. The provider had engaged with an external fire safety consultant who completed an extensive review of the designated centre. Following this a programme of works was developed which was prioritised based on risk. The provider was actively working to this programme of works and there were contractors onsite carrying out works at the time of this

inspection. In addition, the responsible person for the implementation of these fire works on behalf of the provider, along with a representative of the provider, showed an inspector all the works that had been completed to date.

The fire doors in place were all in working order and each door had been fitted with a door closure. Another 30 sets of fire doors had been ordered and were due to be fitted to replace older fire doors. A significant piece of fire proofing had been completed between the ground floor and the first floor and the fire contractors were systematically working through zones ensuring each was fully compliant before moving to the next. Whilst these works were ongoing some residents were temporarily moved to other bedrooms in the centre. This had been discussed with residents and risk assessments had been completed to cover all aspects of the works being carried out.

The centre's evacuation plan and the arrangements for fire wardens had been reviewed. Residents' personal emergency evacuation plans (PEEPs) were reviewed and updated and additional staff had been deployed to cover night duty in the event of a fire whilst the upgrade works were being completed. The inspectors noted that fire drills had occurred since the most recent inspection; four of these were reviewed and for the most part (with the exception of staff on longer term leave) all staff had participated in the drill with a particular focus on bed evacuation at night-time. Enhanced site specific fire training also took place for staff working at the centre.

Some areas for further improvement were found and required a review, including the completion of daily fire checks (some gaps noted), the storage of oxygen, and obstruction of fire doors. Finally, while the provider had engaged their employees in additional training and simulated fire drills, fire drills had not been completed with agency staff. The provider had assigned agency staff to work daily until such time as the fire works were completed.

Regulation 12: Personal possessions

Some practices in place restricted residents' access to their own personal finances. Residents' moneys were paid into an account with a second account holder who was a previous employee of the organisation; this had not been identified at the provider's own financial audits or reviews.

The support arrangements in place for one resident were not ensuring that the resident had access to their own money and placed considerable limitations on their quality of life. This had been recognised as a potential safeguarding risk by the provider, and while there was evidence that the provider had endeavoured to address this, it had not been addressed in a timely manner and at the time of inspection an effective safeguarding plan had not been developed.

Judgment: Not compliant

Regulation 13: General welfare and development

Residents had very limited access to opportunities for recreation, leisure or education. This had been further compounded by the closure of day services due to COVID-19 restrictions. While it was noted that day services were due to reopen, and that residents would return to day services in weeks following the inspection, the inspectors were not satisfied that the provision of day service was based on the individual needs and abilities of each resident.

Records reviewed indicated that residents rarely left the building that the centre was located in, with one day service located on the ground floor of the same building. Residents were seen to be isolated from the wider community with limited access to services in their local community.

While some activities were seen to be provided in the centre, these appeared to be spontaneous with no clear activity plan in place. Inspectors also found that there were minimal resources for residents to engage in activities in their home.

Residents days were seen to be dictated by the needs of the centre and staffing arrangements.

Judgment: Not compliant

Regulation 17: Premises

While improvements had been made since the most recent inspection, in particular with regards to repairs, maintenance and the acquiring of new equipment such as a fridge, the premises continued to be an institutional type building with an overall aesthetic which was clinical in nature.

There were also some areas where further repairs and maintenance were required such as:

- A significant amount of painting was required.
- Wallpaper in a number of bedrooms was peeling.
- Floors throughout the centre were marked and some tears in the linoleum were also observed.
- Curtains in one bedroom were not in working order and were coming away from the rail on one side.
- One of the bathrooms had damage to the walls.
- There was rust on a number of radiators.

- There was mould observed in one bathroom.

The inspectors acknowledge the provider has intentionally delayed completing the repairs to the floors and the painting works until the extensive fire works were completed.

Judgment: Not compliant

Regulation 18: Food and nutrition

Overall, it was found that while there was adequate and nutritious food available, the arrangements in place did not represent genuine choice or participation. Residents were not supported to prepare and cook their own food, had limited access to the kitchen area, and meal choices were based on a predetermined menu.

It is acknowledged that staff endeavoured to communicate residents' preference to the central kitchen in order to influence menu choices, however as the kitchen catered for a number of services, individual requests could not always be facilitated.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place and ensured that risk was placed on agendas at both management and team meetings.

An incident and accident log was maintained, and at the end of each quarter the person in charge reviewed the types of incidents and accidents that were occurring. Learning from this was discussed at team meetings.

A risk register was maintained and kept in the centre. It had been updated since the time of the last inspection.

Judgment: Compliant

Regulation 27: Protection against infection

While the provider had made improvements with regard to infection, prevention and control (IPC) the inspectors found that not all areas of IPC risk had been captured on the audits and further areas for improvement remained.

The inspectors were not assured that all areas and surfaces in the centre could be cleaned appropriately and consequently could contribute to an infection control risk. Repair or replacement of surfaces were required in areas such as;

- Wallpaper in a number of bedrooms was peeling
- Flooring throughout the centre were marked and some tears in the linoleum were also observed
- One of the bathrooms had damage to the walls and was not fully sealed
- There was rust on a number of radiators
- There was tape attached to some walls and windows which compromised effective cleaning.

Other areas of concern that were found at the time of inspection, which were not identified in the centre's recent audit included;

- Inappropriate storage of mops
- Insufficient number of sinks readily available to staff in order for them to perform hand hygiene subsequent to supporting residents with personal care.
- Incorrect storage of sharps bins; two sharps bins were observed to be located on the floor in the staff office.
- A number of boxes were stored on the floor which meant the floor could not be cleaned properly. This was rectified at the time of inspection.
- The material on some of the moving and handling equipment, such as hoists, was torn and therefore could not be thoroughly cleaned
- The inspectors were not assured by the cleaning practices in place for equipment such as nebulisers with one observed to be visibly unclean.
- The inspectors observed staff, on a number of occasions, use PPE incorrectly.

Judgment: Not compliant

Regulation 28: Fire precautions

Subsequent to the most recent inspection, the provider had engaged with an external fire safety consultant who completed an extensive review of the designated centre. Following this, a programme of works was developed; inspectors found that works were being carried out in line with the time frame submitted in the provider's compliance response.

At the time of this inspection there were contractors in the centre completing the planned fire safety works. The provider outlined that all works would be completed by February 2022.

The inspectors reviewed the fire check records and found that there were some gaps with regards to completion of daily checks. There were four instances when daily fire checks were not recorded as being completed, all of which were for the

month of October.

The inspectors noted that there was enhanced storage of oxygen, however a small cylinder used for one resident was observed to be inappropriately stored on top of a table in the lounge area for the majority of the time whilst the inspection occurred. This was moved to a more suitable location following numerous requests by inspectors.

A fire door was also observed to be wedged open during the initial walk-around of the centre and another door was obstructed by a mop bucket and mop.

The provider had assigned agency staff to work daily until such time as the fire works are completed. However, it was noted that fire drills had not been completed with agency staff.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Not all staff had received training in positive behaviour support appropriate to their role. At the time of inspection, 12 staff members required training in positive behaviour support.

Judgment: Substantially compliant

Regulation 8: Protection

While there were arrangements in place to identify and respond to safeguarding risks, a known risk had not been escalated or investigated in line with the provider's own policy. This is discussed further under the regulation 'personal possessions'.

There were care places in place with regard to the provision of intimate care, however it was found that these contained very little information about residents' needs and preferences. The inspectors were not satisfied that residents' views and preferences were fully considered or that support plans were adequately informed to ensure the delivery of person centred and dignified care.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Baldoyle Residential Services OSV-0002340

Inspection ID: MON-0034325

Date of inspection: 20/10/2021

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: • The Organization has in place a procedure to ensure that the recruitment of staff is appropriate to the number and assessed needs of the residents in the designated centre. • There is currently a full staff compliment in the Designated Centre. • A new full time CNM1 will commence in 10th January 2022 • A Roster review was completed by the Person in Charge to ensure the provision of consistent staffing with suitably qualified staff was available. Nursing requirements have reduced since date of inspection a further review will be commenced on 17th January 2022. • A review of skill mix of staff within the DC will be completed by 28th February to explore the possibility of a model of service delivery combining nursing and social care supports. 2 HCAs currently working in the centre have commenced social care degrees.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A Comprehensive recording system is now in place for the tracking of mandatory training needs and where, identified training sourced within specified timeframes. PIC is now tracking training needs for all staff and Training records are now available in the centre • Ongoing Training Needs Analysis have been completed for each staff member, the most recent being 20/12/2021	

• All staff are supported to maintain their competencies through professional development.
• Supervision / Support meetings are scheduled with staff and through this process training needs are identified and sourced.
• Training schedule allocation has been developed by PIC to provide support to staff who have outstanding training needs.
• 7 staff completed First Aid training on the 13th December, remaing staff are scheduled for training in Janaury and February 2022.
• All staff have completed the provider's online fire training
• All staff completed Children's First training.
• All staff completed safeguarding training.
• 2 of the 3 staff staff completed food safety training.
• All staff completed safe moving and handling training.
• Person Centred Planning training has commenced - 18 staff have completed this, and all staff are scheduled to complete same by 28th February 2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A Service Improvement Team (SIT)has been established by the CEO and chaired by the Director of Operations. The service improvement team have agreed Terms of Reference, revised on the 17/12/21 and addendum attached. The SIT have a comprehensive work plan to address the non-compliances with regulations. The SIT meets every two weeks and have an agreed agenda and actions to be completed.
• In relation to regulation 28: fire,
o An Independent fire engineer was appointed to project manage all fire upgrade works on the 9/9/2021. All upgrade works are been completed in line with risk assessments and timeframe.
o Fire Training has been completed by all staff
o Enhanced fire evacuation training arrangements remain in place for relief and agency staff to ensure familiarity with updated fire evacuation arrangements.
o Daily fire check lists are in place and are completed in line with policy and procedure. Updated review process is in place to ensure these are completed accurately. If there are any actions required these will be escalated to PIC/ CNM1/ PPIM for immediate follow up.
o A further review of the storage of oxygen cylinders has been addressed with staff team.
• In relation to regulation 27: Protection against infection
o Immediate remedial works to address IPC concerns were completed and a full IPC audit conducted by SMH Infection Prevention & Control Nurse. All actions from this audit and inspection including painting and replacement of flooring will be completed when fire upgrade works are concluded.

• Activity timetables within the center will be reviewed with a focus on personal choice and preference of residents and in line with PCP.
• Person Centred Planning training has commenced 18 staff have completed this, and all staff are scheduled to complete same by 28th February 2022.
• Additional information sessions will be provided to all staff on the implementation and activation of appropriate activities for all residents, all about me process which will inform this work
• A capital decongregation business case will be re-submitted, as requested, to HSE CHO DNCC by 5/1/21.
• A Full 32 regulation Audit has been completed and updated in December 2021. An action plan has been developed and is being implemented with oversight from SIT.
• All residents will return to day services by the 10th January 2022, all residents have been consulted in relation to this.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• All residents finance accounts are currently being reviewed and updated.
• Support plans for residents are being updated to provide an individualised approach to managing money.
• The SMH safeguarding committee is currently reviewing all residents' access to their finances.
• St Michael House is currently implementing a pathway to support resident's have full access to their finances.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• All residents have a personal plan in place outlining their needs and supports in accordance with their wishes. These are currently under review, a process that began in September 2021, supported by the PCP coordinator. Four residents personal plans have been reviewed and staff team are implementing.
• Person Centred Planning training has commenced 18 staff have completed this, and all staff are scheduled to complete same by 28th February 2022.
• All About Me are in place for each resident.
• All residents are involved in the person centered planning process and a 'My Life

Meeting' will be scheduled for each resident within the 1st Quarter of 2022 with the involvement of MDT team as appropriate the resident is supported to attend this meeting.
• All residents will be returning to their day service schedule from 10/1/2022
• Day Service options will be reviewed to establish suitable service to meet resident's needs.
• A subgroup of the SIT including membership of Quality dept and current Day service PIC and staff will carry out review of day services needs for all residents and develop recommendations to inform referrals to SMH Day waitlist by 30th June 2022.
• Consultation with residents in relation to location of bedrooms in the centre is under way.
• Activity timetables for all residents will be reviewed with a focus on personal choice and preference of residents.
• Additional information sessions will be provided to all staff on the implementation and activation of appropriate activities for all residents, with a focus on personal choice and preference of residents and will include community activities.
• A review of documentation and timetables that are currently in place to be carried out, this is to include evening and weekend activities so that enhanced opportunities for social inclusion is captured.
A capital decongregation business case will be re-submitted, as requested, to HSE CHO DNCC by 5/1/21.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A Schedule of works is in place for the centre to include the following;
o Corridor flooring will be replaced when fire upgrade works are completed
o Quotes for the painting of the premises have been received and will be completed when fire upgrade works are completed
o Wallpaper peeling in two of bedrooms will be addressed.
o Damaged walls in one bathroom will be addressed.
o Rust on radiators will be addressed.
o Mould in one bathroom will be addressed.
• The curtain in one bedroom is now in working order.
• Both kitchens have been replaced
• Cooking facilities will be installed in both dining areas
All cleaning routines will continue to be revewed and a comprehensive system of checklists for confirming cleaning routines re-estbalished

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• Meal planning is discussed at residents' meetings and any suggestions/issues/meal ideas are conveyed to the kitchen staff who will then trial new dishes and seek feedback from residents. Records of this are available.
• Alternative options to the daily menu are available to provide choice.
• To enhance choice and personal preference Kitchen cooking facilities will be installed into both kitchen areas in the designated centre to provide opportunities for meal options and cooking experiences.
• PIC will liaise with dietician around meal plans.
• Meal alternatives and snacks and drinks are always available in residential centre.

Regulation 27: Protection against infection	Not Compliant

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

• All staff have competed Covid 19 training
• All cleaning routines have been reviewed and a comprehensive system of checklists for confirming cleaning routines have been re-estbalished
• 1 staff nurse will attend IPC Link Practitioners Programme in April 2022 and will gain the knowledge to play a key role in ensuring compliance with IPC within the centre.
• Enhanced cleaning systems in place for the cleaning of nebulizers
• Housekeeping staff in place.
• A review of IPC audit will take place by 31st January 2022 and a full IPC audit will be conducted by SMH Infection Prevention & Control Nurse on the completion of all upgrade works in February 2022.
• Corridor flooring will be replaced when fire upgrade works are completed
• Quotes for the painting of the premises have been received and will be completed when fire upgrade works are completed
• Tape attached to wall and windows has been removed
• Rust on radiators on the completion of all upgrade works in February 2022.
• Mops storage was reviewed on the day of inspection
• Sharps bins are stored in a locked press
• All damaged material on equipment has been replaced
• The appropriate use of PPE has been discussed at staff meeting on 17/11/21 & 11/12/2021
• Hand gels dispensers have been increased in the centre to ensure they are in the following places;
- outside all bedrooms areas
- laundry rooms
- utility rooms

· outside bathrooms
· kitchen and dining areas
· outside sitting rooms
· Outside office

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Independent fire engineer appointed to project manage all fire upgrade works 9/9/2021. All upgrade works are being completed in line with risk assessment and timeframes. Verification letter received from project manager on the 21/12/2021.
• Staff are assigned to residential duties on each shift and these staff are responsible for ensuring fire checks are completed.
• Weekly Audit of fire checks by PIC and PPIM with follow up of any issues with non completion
• New agency staff are given an induction to Baldoyle which includes fire evacuation procedures and watching a fire evacuation training video which is specific to Baldoyle.
• Further fire evacuation training is scheduled for 11th January 2022

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All staff have now completed online PBS training.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• St Michael's House has a policy in place for safeguarding vulnerable adults in line with national Policy & Procedure.
• Safeguarding training for all staff has been completed.
• The SMH safeguarding Committee / sub group are currently reviewing a pathway to ensure all residents have access to their finances. This work commenced in September

2021
• Residents access to finance is currently being reviewed by SMH Designated Officer the initial meeting took place on the 17/12/21
• All staff have up to date training on safeguarding vulnerable adults.
• All staff have completed Children's first training via the HSE.
• PCP Coordinator has been reviewing all assessments of need and corresponding support plans ,a process that began in September.
• Four residents personal plans have been reviewed and staff team are implementing recommendations.
• All intimate care support plans to be reviewed and updated to include needs and preferences' to ensure person centered and dignified care by 31/1/22.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/03/2022
Regulation 12(3)(b)	The person in charge shall ensure that each resident is supported to manage his or her laundry in accordance with his or her needs and wishes.	Not Compliant	Orange	30/03/2022
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with	Not Compliant	Orange	30/06/2022

	evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.			
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/06/2022
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	30/06/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/01/2022

Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	30/12/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	28/02/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/03/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/03/2022
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure	Not Compliant	Orange	30/03/2022

	that residents are supported to buy, prepare and cook their own meals if they so wish.			
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Substantially Compliant	Yellow	30/03/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/12/2020
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	28/02/2022
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre	Substantially Compliant	Yellow	30/03/2022

	and that such care and support is in accordance with standards.			
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	30/04/2022
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Substantially Compliant	Yellow	28/02/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	28/02/2022
Regulation 28(3)(d)	The registered provider shall make adequate	Substantially Compliant	Yellow	30/12/2021

	arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety 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.	Not Compliant	Orange	30/12/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/01/2022
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	Substantially Compliant	Yellow	30/03/2022

	respects the resident's dignity and bodily integrity.			