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:	Royal Oak
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	13 January 2022
Centre ID:	OSV-0002361
Fieldwork ID:	MON-0027155

About the designated centre

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

Royal Oak is a designated centre based in a North Dublin suburban area and is operated by St Michael's House. It provides community residential services to three male residents with intellectual disabilities over the age of 18. The designated centre is comprised of two attached houses with an internal door for access. The designated centre consists of five bedrooms, two kitchen come dining rooms, two sitting rooms, an office, two bathrooms and two toilets. There was a garden to the rear of the centre which contained two small buildings which were used for laundry and storage. The centre is located close to amenities such as shops, cafes and public transport. The centre is staffed by a person in charge and social care workers. Staff have access to nursing support through a nurse on call service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Thursday 13 January 2022	09:40hrs to 17:10hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with all of the residents on the day of inspection. Some residents chose to speak with the inspector in more detail about their experiences of living in the designated centre. All residents had also completed questionnaires in advance of the inspection and these were made available to the inspector. In line with public health guidance, the inspector wore a face mask and maintained physical distancing at all times during interactions with residents and staff. The inspector used observations, discussions with residents and staff, resident questionnaires and a review of documentation to form judgments on the quality of residents' lives in their home. Overall the inspector found that, while the designated centre was striving to provide an individualised service, improvements were required to the governance and management and infection, prevention and control (IPC) arrangements. The governance and management arrangements required strengthening to ensure residents were in receipt of a good quality and safe service. This will be discussed in more detail in the Capacity and Capability section of the report.

The inspector observed residents coming and going from the centre during the day. At the time of inspection, resident day services had been suspended due to an increase in COVID-19 cases. The residents in Royal Oak were supported to engage in activities in their home and in the community instead of attending day services. Some residents were observed leaving the centre to go to work while others were supported to engage in activities related to their preferred interests including working on the computer, playing cards, going on the DART or going to the airport to watch the planes. One resident showed the inspector photographs of activities that they had engaged in with the support of staff over the last year. Residents also showed the inspector folders of completed education modules and awards that they had achieved. Residents were well supported to participate in educational and recreational activities as well as employment in the community, in line with their assessed needs and individual preferences.

The majority of residents stated that they were happy living in the designated centre and felt well supported by the staff team. However, one resident informed the inspector, through their questionnaire, that they were frustrated with the living arrangements and were unhappy living in the designated centre.

The inspector observed staff and residents interacting in a familiar and comfortable manner. Staff appeared to know the residents well and could talk competently about residents' preferences and likes as well as their assessed needs. Residents and staff were observed sharing jokes and laughing. Staff were observed supporting residents to complete tasks of daily living and were seen to promote residents' independence skills. Staff were also observed supporting residents to engage in activities of their preference such as playing cards. Overall, the atmosphere in the house was familiar and relaxed.

The inspector observed that the designated centre was in need of repair and cleaning, both internally and externally. Sitting room furniture required replacing and there was re-plastering and painting required to several areas of the houses. There were several premises issues which also presented a risk to infection prevention and control (IPC). For example, the cupboard laminate in one kitchen was badly peeling and, therefore, could not be thoroughly cleaned. The fridge was observed to be dirty and there was evidence that the cleaning schedule was not fully adhered to. The kitchens and bathrooms also required a deep clean. There were several items of furniture in the back garden which were awaiting disposal. The paint around the external sides of the houses was also badly peeling and flaking off.

In general, the inspector found that the centre was striving to provide an individualised service within a social care model. However, improvements were required to the governance and management arrangements to ensure that residents were in receipt of a good quality service which was being provided in a suitably clean and safe environment.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and to contribute to the decision-making process for the renewal of the centre's registration. The inspector found that enhancements were required to the governance and management of the designated centre to ensure that all services provided were safe, responsive to resident wishes and needs and were effectively monitored.

At the time of inspection, there was a full-time person in charge in place who was suitably qualified and experienced. While the person in charge had been allocated dedicated management hours, these were not always taken, as reflected on a review of the centre's rosters. This contributed to a lack of consistent planning in order to drive quality improvement in the designated centre. While the provider had completed monthly data reports, six monthly audits and an annual review, these were not comprehensive and did not consistently reflect the presenting risks and issues in the designated centre. For example, a health and safety audit completed in December 2021 stated that work areas were clean, tidy and well kept. However, it was seen on inspection, and documented on the biannual review in July 2021, that the kitchen required repair.

Goals which were derived from the provider's audits were generic and did not drive quality improvement. Goals from the annual review did not reflect the risks identified and were not specific, measurable or time-bound. Additionally, while the annual

review set out that residents were consulted with, the residents' views were not used to inform goal setting for the service. For example, one resident's frustration with the living arrangements was documented in the annual review. However there were no comprehensive plans in place to address this.

The provider's biannual audit in July 2021 identified several premises issues which required addressing. These were not addressed by the time of the second audit in December 2021. This demonstrated that the provider's audits were ineffective at addressing known deficits in a timely manner. There was further documented evidence that the provider had failed to repair broken appliances in a timely manner which had a negative impact on the quality of life for residents. Residents and staff reported that the dishwasher and tumble dryer had been broken for approximately five weeks which resulted in residents drying their clothes indoors.

A review of the centre's roster was completed which demonstrated that there was adequate staffing in place which was appropriate to the residents' assessed needs and was in line with the statement of purpose. Where relief staff were required, these came from a panel of familiar relief and agency staff which supported continuity of care for the residents.

A staff training matrix was maintained which demonstrated generally a high level of mandatory and refresher training for staff. Some staff required training in mandatory areas including COVID-19, Fire Safety and Children First. Half of all staff required refresher training in First Aid. While the person in charge reported that staff supervisions were completed, the records were not maintained in such a way to show that they occurred as frequently as prescribed by the provider's policy. A sample of supervision records were reviewed.

A review of the notifications submitted in the centre found that not all notifications were submitted within the time frame as determined by the regulations. The reason for this was given as there were insufficient arrangements in place for staff to submit notifications in the absence of a person in charge.

The centre's statement of purpose was reviewed and was found to contain the documentation as required by Schedule 3 of the regulations. The designated centre had also effected a contract of insurance against injury to residents, a copy of which was furnished to the Chief Inspector.

Regulation 14: Persons in charge

The centre was staffed by a full-time person in charge who had the necessary skills and experience to manage the designated centre. the person in charge had sole oversight of the current designated centre and was not responsible for any additional centres.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual roster was maintained for the designated centre. A review of the roster demonstrated that staffing was in line with the assessed needs of the residents and as per the statement of purpose. Where relief staff were required, these came from a small panel of regular relief and agency staff. This supported continuity of care for the residents.

Judgment: Compliant

Regulation 16: Training and staff development

A training matrix was maintained for the designated centre which detailed that there was generally a high level of mandatory and refresher training maintained for staff. The overall level of compliance with training was at 87%. The following areas were identified as deficits on the training matrix:

- Fire safety: 1 staff required this
- COVID-19: 1 staff required this
- Children First: 1 staff required this
- Food Safety: 1 staff required this
- Feeding, eating, drinking and swallowing: 1 staff required this
- First Aid: 50% of staff required this

While there was evidence that staff supervisions were completed the supervision records were not adequately maintained and it was therefore unclear if staff supervisions had been completed as frequently as determined by the provider's policy.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had effected a contract of insurance against injury to residents. A copy of the provider's insurance certificate was furnished to the Chief Inspector with their registration renewal application.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had in place several audit mechanisms however these were not effective at consistently identifying areas for improvement in the designated centre and did not ensure that risks were responded to in a timely manner.

While residents were consulted with during the annual review process, their views were not used to inform goal setting. Goals were generic and were not specific to either the issues arising in the centre or to the residents' assessed needs and expressed wishes. Goals from the annual review did not reflect the risks identified and were not specific, measurable or time-bound.

There was evidence of poor oversight of infection prevention and control procedures in the designated centre. Staff reported that they were unaware of the most recent guidance regarding the wearing of personal protective equipment (PPE) and therefore were not wearing the correct type of face covering. Monthly health and safety checklists were maintained. However these were inaccurate and did not reflect the health and safety risks in the centre.

The provider had failed to ensure adequate oversight of staff training and development. There was evidence that where staff had consistently failed to complete available mandatory online training, that they were not performance managed to ensure that they exercised their professional responsibility for the quality and safety of service that they were delivering.

Judgment: Not compliant

Regulation 3: Statement of purpose

The centre's statement of purpose was found to contain all of the information as required by Schedule 3 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of the incident log in the designated centre identified that not all adverse incidents were referred to the chief inspector within three working days as required by the regulations.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of the service and how safe it was for the residents who lived in the designated centre. Overall, the inspector found that the service was striving to offer a person centred and individualised service however improvements were required to the premises, the arrangements for infection prevention and control (IPC) and the measures in place to ensure residents' rights and preferences were supported with comprehensive care plans.

The inspector completed a walk through of both houses which comprised the designated centre. Both houses required maintenance, redecoration and deep cleaning. There had been a significant leak through the ceiling of one sitting room. While the leak had been repaired, there were several holes in the ceiling of the sitting room which had not been fixed. Painting was required throughout both houses in particular in the hallway and on the upstairs landing of one of the houses. The furniture in the living area of one house required replacement as the armchair and sofa were observed to be sagging and were dirty. An armchair in an upstairs spare bedroom also required replacement. The cover on the armrests was observed to be cracked and peeling. Staff reported that one resident likes to use this room to sit and relax. The peeling cover presented an IPC risk as it could not be adequately cleaned.

The kitchen required refurbishment and cleaning. One kitchen cabinet was observed to be badly cracked and peeling and also presented an IPC risk as it could not be cleaned. The varnish on the kitchen table and on the banisters in the house had also worn away which presented a further IPC risk. There was evidence of poor standards of cleanliness in the kitchen. A cleaning scheduled had not been completed for the day before inspection. The kitchen presses were observed to be dirty on the outside and there were crumbs and food residue in the cutlery drawer. A spillage of a red substance was found under the vegetable basket in the fridge. This was cleaned by staff on the day of inspection. The poor standards of cleanliness were particularly concerning given that there had been a recently confirmed case of COVID-19 in the centre. The centre's COVID-19 house plan stated that enhanced cleaning was to occur in the event of a suspected or confirmed case of COVID-19 however it was evident that this action had not been implemented.

Bathrooms were generally clean and contained hand wash and disposable hand towels. However there was black mould in the drain of one shower. The inspector also saw rust on the radiators in the bathrooms. This presented an IPC risk as they could not be adequately cleaned. They also did not contribute to a homely environment.

Resident bedrooms were observed to be decorated in line with individual preferences. One resident showed the inspector their bedroom and was proud of it.

They had access to their preferred activities for entertainment in their bedroom including DVDs, a TV and a games console. The resident reported that their bedroom can feel cold. The inspector saw that blinds in resident bedrooms were dirty and were broken in one bedroom.

The premises generally appeared unkempt. There were cobwebs and dead spiders observed around an emergency light, a build up of bird excrement on a skylight and significant peeling of exterior paint on the sides of the houses. There were several large items of furniture in the back garden which were awaiting disposal.

In addition to the IPC risks presented by the premises issues, the inspector saw that the provider had not implemented effective procedures to protect residents and staff from contracting a healthcare associated infection. On the day of inspection, staff were not wearing the correct personal protective equipment (PPE) as set out by the most recent public health guidance. Staff informed the inspector that this was not due to a lack of availability of the the PPE but rather that they were unaware of the most recent guidance. The inspector also saw that there were insufficient measures in place to ensure that PPE was disposed of in a safe manner. Staff were using a bin bag on the floor by the front door to dispose of PPE rather than a pedal operated bin. This was inadequate and put staff and residents at risk of exposure to contaminated PPE.

The guidance in place for staff around the management of COVID-19 was not comprehensive or specific. For example, the COVID-19 house plan detailed that increased cleaning of common areas was to take place in the event of a suspected case. However, there was no information on the specific areas to be cleaned, the frequency of cleaning or the products to be used to ensure they were effectively sanitised.

A review of resident files demonstrated that residents had an up-to-date assessment of need that had been recently reviewed. For the most part, each assessed need was supported by a comprehensive care plan which was written in a person-centred manner. Goal planners were also in place to support residents to achieve their goals. However, the inspector saw that one resident had expressed as part of their assessment of need that they would like to live independently. This wish was discussed at multidisciplinary meetings and various assessments, interventions and alternative living arrangements were proposed. However there was no comprehensive care plan in place or goal planner to support this resident to work towards their goal.

One resident showed the inspector their ''All About Me'' care plan which was presented in an accessible manner as per the resident's preferences and assessed needs. The resident told the inspector about their keyworker and was happy with how their keyworker consulted with them regarding the running of the designated centre.

Resident files showed that residents had access to a variety of healthcare professionals including psychology, social work and general practitioners as required. There was evidence that when residents declined treatment that their right

to do so was respected. Care plans were up-to-date for assessed medical needs.

All staff had up-to-date training in managing behaviour that is challenging. There were some restrictive practices in place in relation to access to food however these did not impact on all residents. For example, one resident had requested their own fridge to store their food and they kept this locked as was their preference. Behaviour support plans were in place and had been recently reviewed. However, enhancements were required to the behaviour support plans to ensure that the reactive strategies detailed could be applied to the residential setting. For example, some reactive strategies set out in a behaviour support plan, such as observing the resident through a window, could not have been implemented in the designated centre.

Additionally, there was a mismatch of information between a resident's behaviour support plan and their psychiatry guidelines for PRN medication. The psychiatry guidelines stated that staff should consult the positive behaviour support guidelines for steps on administering PRN medication however these steps were absent from the positive behaviour support plan when reviewed. This meant that staff may not have been aware of the correct procedure for administering PRN medication and therefore may not have been applying therapeutic interventions in line with evidence based best practice.

All staff had completed training in safeguarding. Staff spoken with were knowledgeable regarding safeguarding, how to identify abuse and the procedure to be followed if they had a safeguarding concern. Safeguarding incidents were recorded and notified to the relevant statutory authorities. There was evidence that safeguarding plans had been implemented where required. Intimate care plans were in place on resident files. These had been recently reviewed and were written in a person-centred and respectful manner.

A risk register was maintained for the designated centre however the risk register did not set out many of the risks identified on the day of inspection, including in relation to the IPC arrangements and premises issues. Where risks had been identified, these were risk rated and there was a risk assessment in place which set out strategies to mitigate against risks.

The registered provider generally had effective mechanisms in place to mitigate against the risk of fire. These included an up-to-date fire safety management plan, regular fire checks, serviced fire fighting and detection equipment and fire containment mechanisms such as automatic door closers. Residents had participated in fire drills and fire walks as frequently as set out by the provider's fire policy. The inspector saw however, that one resident chose to keep their bedroom door locked. While this was respectful of the resident’s rights, the provider had not risk assessed this and did not have a contingency plan in place should they need to gain access to the resident in their bedroom in the event of an emergency. The centre's fire risk evaluation set out that the centre required smoke detectors to be installed in the velux window cavities and that there was one remaining automatic door closer to be fitted to one resident bedroom.

Regulation 17: Premises

The designated centre was in need of maintenance and refurbishment. The premises issues identified included:

- worn and dirty armchairs and sofa
- unrepaired holes in kitchen and ceiling walls
- general painting required internally and externally
- Kitchen cabinets cracked and peeling
- broken or dirty blinds in resident bedroom
- garden maintenance and removal of old furniture
- deep cleaning of premises required

Judgment: Not compliant

Regulation 26: Risk management procedures

A risk register was maintained for the designated centre and up-to-date risk assessments were available for identified risks. Risk assessments were detailed and provided clear measure for staff on how to mitigate against identified risks. However, the risk register did not comprehensively identify several risks in relation to premises and infection prevention and control as were evident to the inspector on the day of inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

In addition to the infection prevention and control risks presented by the premises issues, the provider had not implemented effective procedures to protect residents from acquiring a healthcare associated infection. Staff were not aware of the most recent public health guidance in relation to COVID-19. Staff were observed to be wearing the incorrect type of face masks and attributed this to being unaware of the guidance, rather than to a lack of appropriate PPE. There were insufficient bins for disposing of used PPE. The guidance in place to support staff in managing a suspected or confirmed case of COVID-19 was not comprehensive or specific.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider generally had effective mechanisms in place to mitigate against the risk of fire. Fire drills and fire walks were completed in line with the provider's policy and detailed that all residents could be evacuated within a reasonable time frame. The provider had in place fire fighting, detecting and containing equipment which was regularly serviced.

The provider had plans to install one outstanding door closer on a resident bedroom door. The resident had previously refused this however the provider was engaging with the resident in an attempt to balance the resident's preferences and rights with the safety issues presented by a lack of self-closing mechanism.

The provider's fire report detailed that the centre required smoke detectors to be installed in velux window cavities.

A risk was identified on the day of inspection whereby the provider could not demonstrate that they would be able to safely evacuate one resident in the event of the resident failing to respond during an emergency evacuation as they did not have a key to this bedroom.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had an up-to-date assessment of need which had been recently reviewed. Most assessed needs were supported by comprehensive care plans which were written in person-centred language. It was identified on one resident's assessment of need that they would like to live independently. There was no comprehensive care plan in place which showed how the provider was addressing this and supporting the resident's wish.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a variety of healthcare professionals as per their assessed needs and care plans. There was documented evidence that where residents

refused medical assessment or intervention that this right was upheld.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that staff had access to training in managing behaviour that is challenging. Behaviour support plans were in place and were written in person-centred language. However, enhancements were required to these plans to ensure that they provided comprehensive information to staff on managing behaviour that is challenging in the residential setting including the circumstances in which PRN medication should be administered.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had systems in place to protect residents from all forms of abuse. Where safeguarding incidents occured, these were notified to the relevant authorities and safeguarding plans were implemented. All staff had received training in safeguarding. Staff spoken with were knowledgeable regarding detecting, recording and reporting abuse. Intimate care plans were written in a person-centred and respectful manner and detailed measures to respect residents; dignity and bodily integrity.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Royal Oak OSV-0002361

Inspection ID: MON-0027155

Date of inspection: 13/01/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Staff member has completed all outstanding training as of 11/02/2022. PIC has updated the training log to reflect this. • 2 staff scheduled to complete First Aid training on 23/02/22 & 24/02/22. Remaining two 2 staff are on waiting list for training. • All staff supervisions are now adequately maintained and will be kept in a locked drawer available only to PIC. Records will be availible for inspection when requested. Schedule in place for PIC staff supervision meetings for the coming year and in line with SMH supervision policy.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC and Service Manager will ensure that all issues raised through audits and reviews will be acted upon in an timely and appropriate manner these will be discussed at the monthly meeting. • A new PIC has been appointed to the centre and commenced on the 14/2/2022 • The PIC will use feedback from residents to inform person centred planning for resident to include goal setting that are SMART in format to be included in annual review. • All identified risks from residents feedback will be assessed and used to update supports provided to residents. • All staff are now fully aware of the most recent public health guidance and now wear	

the correct face covering (FFP2) while on duty.
• Staff are informed of where to access all updated guidance relating to Covid 19 and IPC. All staff have completed Covid 19 and IPC training online.
• New bins have been purchased; there is now a sufficient amount of bins to dispose of used PPE as of 28/01/2022.
• Covid house Plan has been reviewed.
• Monthly IPC checklist is in place as of 01/02/2022.
• HIQA IPC self assessment audit has been completed and will be reviewed by 28/02/2022.
• A copy of latest public health guidelines, are in place in centre to inform good practice.
• The PIC and Service Manager will ensure that all Monthly Health & Safety checklists within the centre are accurate and acted upon in a timely manner.
• The PIC has reviewed all training needs of staff. Any delays in training being completed will be notified to Service Manager.
Annual review for 2021 has been reviewed to ensure all actions are addressed appropriatley .

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC will ensure all incidents will be notified to the chief inspector within 3 working days of an incident occurring as per regulatory requirements.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• New kitchen tables & chairs, Sofa and armchair has been ordered and will be delivered before 28/02/2022
• All damage to wall and ceilings have been repaired throughout the centre as of 11/02/2022
• Painting of the center will be completed by 28/02/2022.
• New kitchen has been installed as of 11/02/22.
• New blinds for resident's bedroom due to be installed by 18/02/2022.
• Removal of old furniture from the garden has been completed as of 14/01/2022
• Deep clean of the centre has been organised will be completed by 28/02/22.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• All risks in relation to premises and infection prevention have been reviewed work has been completed in the centre and this will be reflected in the risk register.
• Hygiene Audit is scheduled to take place by 31/03/22, any actions arising from audit will be included in related Risk Assessments .

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• All staff are now fully aware of the most recent public health guidance and now wear the correct face covering (FFP2) while on duty.
• Staff are informed of where to access all updated guidance relating to Covid 19 and IPC. All staff have completed Covid 19 and IPC training online.
• New bins have been purchased; there is now a sufficient amount of bins to dispose of used PPE as of 28/01/2022.
• Covid house Plan has been reviewed.
• Monthly IPC checklist is in place as of 01/02/2022.
• HIQA IPC self assessment audit has been completed and will be reviewed by 28/02/2022.
• A copy of latest public health guidelines, are in place in centre to inform good practice.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The last outstanding self closing door has been installed as of 28/01/2022
• Smoke detectors have been installed in both velux window cavities as of 21/01/2022
• Arrangements are in place to ensure all resident's can be supported to evacuate, in the event of the resident failing to respond during an emergency as of 14/01/2022

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • A comprehensive support plan is currently being developed with the resident to reflect his wishes to live independently. This support plan will include all supports that have been previously provided to resident. • Goal tracker will be put in place to support resident achieving his goal. • All above actions will be done in collaboration with resident.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Residents Positive Behaviour Support guidelines have been updated to include guidance on PRN medication administration as of 11/02/2022.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/04/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	14/02/2022
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.	Not Compliant	Red	28/02/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the	Not Compliant	Red	28/02/2022

	designated centre are clean and suitably decorated.			
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	Red	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 and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	13/01/2022
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	13/01/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six	Substantially Compliant	Yellow	30/06/2022

	months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	13/01/2022
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	31/03/2022
Regulation 27	The registered	Not Compliant	Red	28/02/2022

	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.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	28/01/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	28/01/2022
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or	Substantially Compliant	Yellow	13/01/2022

	confirmed, of abuse of any resident.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	28/02/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	28/02/2022
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 his or her wishes.	Substantially Compliant	Yellow	28/02/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures	Substantially Compliant	Yellow	11/02/2022

	including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			