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

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| Name of designated centre: | Navan Road - Community Residential Service |
| Name of provider: | Avista CLG |
| Address of centre: | Dublin 7 |
| Type of inspection: | Unannounced |
| Date of inspection: | 02 February 2023 |
| Centre ID: | OSV-0003062 |
| Fieldwork ID: | MON-0034611 |

## About the designated centre

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

This is a centre run by the Daughters of Charity Disability Support Services Company Ltd by Guarantee and is located on the outskirts of Dublin city. The centre can cater for the needs of eight adults, who have a mild to moderate intellectual disability and who are over the age of 18 years. The centre can also cater for residents with specific healthcare needs. The centre comprises one premises which is a two-storey dwelling. Each resident has access to their own bedroom, communal sitting rooms, kitchen and dining area, utility room, shared bathrooms, and a secure garden space is located to the rear of the centre. Staff are on duty both day and night to support residents and the staff team is comprised of a person in charge, a staff nurse, social care workers and carers.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 8 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

**1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

**2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Thursday 2 February 2023 | 09:30hrs to 17:00hrs | Sarah Cronin | Lead |

## What residents told us and what inspectors observed

This unannounced inspection took place to monitor compliance with the regulations. The inspection found residents to be comfortable and content in their home. Staff were striving to provide a person-centred service in line with residents' assessed needs and expressed preferences. Staffing levels and vacancies coupled with changing health care needs posed a particular challenge in the centre and this was found to negatively impact a number of areas of the service. While some good practices were evident, this inspection found poor findings in relation to staffing, governance and management and risk management. These are discussed later in the report.

This designated centre is a large 9 bedroomed detached house based in a suburb in Dublin. There are 7 residents who live in the centre on a full-time basis and one resident who resides there on a part-time basis. Residents presented with complex health and social care needs which had increased significantly since the last inspection. Downstairs comprises a sitting room, a staff office and toilet, 6 resident bedrooms, 2 bathrooms, a utility and kitchen. The kitchen led out to a patio area and there was a yard to the side of the house. Upstairs were three bedrooms and a sitting room which had an area for the residents to make tea and coffee. There was a small office and a shared bathroom. The house was found to be warm, clean and very homely. The walls had professional pictures taken of residents, both past and present together. Each resident had their own room which were highly personalised.

The inspector had the opportunity to meet all 8 residents on the day of the inspection. On arrival, two of the residents were making breakfast. They spoke with the inspector about their home. Both said that they liked living there and spoke about their experience of isolating over the Christmas period. They told the inspector that they met once a week and picked out their menus. Both residents said they got along well together and one said they enjoyed each others' company. They spoke about their family and plans for their day. One of the residents told the inspector that they wished to go to the day service more than their current allocation of one day per week. Another resident was sitting up in their bed after breakfast. They appeared very comfortable and well-cared for. Throughout the day, the inspector observed staff interacting with and caring for the resident in a respectful, kind and gentle manner. They put on music and supported them to sleep and change position regularly.

The inspector met with two other residents in their own bedrooms. Both were watching television, and one resident showed the inspector their tablet which they were playing a game on. They showed the inspector their personal photographs and their clothes. They had previously lived in another house and reported to enjoy living in the centre. Many of the residents had won medals from Special Olympics which they had displayed in their rooms. They spoke to the inspector about what sports they had played and appeared to enjoy reminiscing about the past. There was evidence of family involvement in a number of residents' care including using

video calls with families abroad and involvement of family members in multidisciplinary meetings where appropriate. For a resident who was due to transition to another centre, staff had created a beautiful life story book and a detailed transition plan.

There was a residents' meeting each week and this had a standing agenda in place. Residents rights to communicate using a method of their choice was upheld and respected. The inspector observed good practice in relation to communication with residents. Staff were noted to be on residents' level, to use gesture and Lámh and to support residents in interactions. Communication passports were in place, life story books were available. There were social stories in place to support residents with attending appointments and with transition plans. Consent was sought and documented for care interventions including personal care.

From interacting with residents, many of them reported that the staff were busy during interactions and this had an impact on residents in different ways. For example, one resident reported that they enjoyed going out and going shopping but they couldn't always do this due to staff being busy supporting other residents. Another reported that they would like to go out more. One resident described difficulties in having privacy due to another resident coming into the bathroom. They reported that this generally happened when staff were busy with other residents or tasks. They reported that they sometimes had to wait for personal care tasks until staff were ready to assist them. This issue had also been identified in the provider's annual review, whereby a resident described their wish to go swimming, but being unable to do so due to staff support being required. The review also outlined another example of a resident wishing to maintain a relationship with a friend being difficult to to staff not being available to support them to visit.

Staff working in the centre were clearly dedicated to the residents and there was a feeling of warmth and kindness in the house. It was evident that they knew residents well and that residents were comfortable. However, they too described the staffing levels as having a negative impact on the residents , due to complex care needs taking up a large portion of the day. One staff member spoke about their wish to ensure that residents got out more, but that medical appointments and providing care took up a significant amount of time. This was the cause of frustration on the day of the inspection.

Family feedback from the provider's annual review was reviewed and found to be very positive. Families described the staff as ''the most fantastic team'' and ''friendly and welcoming''. Two family members reported that their relatives were bored and would like more activities in the centre. Residents had completed the providers' satisfaction survey and these indicated that while residents were mostly happy with their living arrangements and reported to feel safe in their home, they did not get to do things they wanted at times.

In summary, it was evident to the inspector that the staff were striving to provide and promote a good quality service for residents and residents were comfortable and well-cared for in their homes. However, there were a number of areas which were negatively impacted by staffing levels and vacancies, resulting in non

compliances. These included governance and management, risk management, staffing, individualised assessments and personal plans and general welfare and development. These are discussed in the body of the report. The next two sections of the report will outline the governance and management arrangements in the centre and outline how these arrangements impacted on the quality and safety of care which residents received.

## Capacity and capability

The provider had a clear management structure in place. The person in charge reported to a person participating in management who was a clinical nurse manager, who in turn reported to the director of services. The person in charge was supported in their role by a shift leaders who took on additional responsibilities in the house. The provider had carried out an annual review, which included input from residents and families. Six monthly unannounced provider visits were also carried out in line with the regulations. However, it was unclear what actions had been taken to achieve improvements in identified areas. The person in charge had a number of systems in place in order to maintain oversight and to monitor the care residents received. There was a schedule of audits being completed in relevant areas but these were not always identifying areas requiring improvement or documenting actions clearly. The person in charge met with their manager every six weeks. They had a meeting with all other persons in charge in the area on a monthly basis and this meeting was used as a platform for sharing information and learning between centres in the region. Staff meetings took place once a month and there was a set agenda in place.

The person in charge was suitably qualified and experienced and knew the residents extremely well. The person in charge had an increase in their supernumerary hours since the last inspection, and now had 19.5 hours of their time allocated to their duties. However, the person in charge reported that this was not always achievable due to the needs of residents and staffing issues.

As mentioned earlier in the report, residents' care needs had increased significantly since the last inspection and the need for nursing care interventions for some residents had also increased. Staffing levels and skill mix in the centre required review in light of the changing needs of the residents and the high number of residents living in the centre. Rosters were not maintained in line with regulatory requirements. While it is noted that the provider had made significant efforts to recruit staff, this had provided ineffective and the lack of a consistent team was impacting significantly upon residents. The inspector found that there had been a large number of different agency staff working in the centre in the weeks prior to the inspection.

Staff training was for the most part in date, with any gaps already identified and in progress. However, the person in charge reported difficulties in accessing some

training in courses in time to maintain their competencies within dates required.

## Regulation 14: Persons in charge

The provider had employed a person in charge who had the required experience and qualifications for the role. The person in charge worked on a full-time basis in the centre. They were found to have detailed knowledge of all of the residents and their changing needs and had systems in place to oversee the centre.

Judgment: Compliant

## Regulation 15: Staffing

The inspector reviewed the rosters and found that these were not maintained in line with regulatory requirements. Full names of staff and their roles were not consistently recorded on the roster. There were staff vacancies on the day of inspection, which were being filled using agency and relief staff. Over a three week period in the month prior to the inspection taking place, there were 31 different staff covering shifts to support regular staff. On the morning of the inspection, there were two staff present in the centre due to a staff member being unavailable for work. Two thirds of the residents required staff support with their care needs, with some of these residents requiring 2:1 staff. Staff members reported that staffing was a cause for concern at times, with one staff member reporting "what we are doing we are doing well but it's not enough". The need for nursing care interventions had also increased since the last inspection. Vacant nursing hours were covered by agency staff and there was an on-call system in place from management to ensure that all required nursing care was received as required. A review of both staffing levels and skill mix was required to ensure that the health and social care needs of all residents in the house were met.

Judgment: Not compliant

## Regulation 16: Training and staff development

All staff had completed safeguarding, training on manual handling, dementia, feeding eating drinking and swallowing difficulties and managing epilepsy. Training in relation to infection prevention and control such as hand hygiene, PPE and infection prevention control was identified as outstanding and in progress on the day of the inspection. However, there was evidence to indicate that for some refreshers, staff were unable to source training in time. For example, for one staff member who

was due to undertake a refresher in the safe administration of medication, the next two courses were full. This caused a delay in staff keeping up-to-date with courses to ensure they had the required knowledge and skills in their roles.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The provider had a clear management structure in place. The person in charge was supported by the clinical nurse manager and they, in turn, reported to the director of services. The person in charge was supported in their role by shift leaders. The provider had carried out an annual review of the centre and this included the voices of residents and their families, as required by the regulations. Six monthly unannounced provider visits had also taken place as required.

Systems within the centre to maintain oversight included audits across a number of areas. While many of these were completed and identified areas requiring improvement, it was unclear how these improvements were progressed or if actions identified in provider visits were taken. The person in charge had additional supernumerary hours assigned to them since the last inspection. However, they reported that these hours were not always completed, due to them providing direct assistance to residents where staffing levels were reduced.

Judgment: Not compliant

## Quality and safety

The inspector found that residents were receiving good quality care in their home. They appeared comfortable and content. Residents were found to have individualised assessments in place which directly informed their care plans. Person-centred plans required improvement to ensure that goals set with and by residents were progressed.

Residents were found to be supported to have best possible health. They had regular access to a GP, to a public health nurse and had input from a specialist palliative care team where it was required. Residents also had access to health and social care professionals within the organisation such as speech and language therapy, occupational therapy, physiotherapy and dietetics. End-of-life care plans were found to be suitably detailed and written using person-centred language.

The provider had a number of policies in place to protect residents from all forms of abuse. There were detailed personal care plans in place which placed an emphasis on each residents' right to privacy and dignity during personal care tasks. There had

been a small number of safeguarding incidents in the centre over the previous year. The inspector found gaps in documentation relating to these incidents, and was therefore not assured that processes required by national policy were followed at all times.

Residents in the centre presented with a range of communication support needs and the inspector found that they were well supported by staff. Interactions were noted to follow residents' lead and staff used simple language, sign and gesture to support residents. Residents had access to activities within the house , largely television, listening to music and playing on a tablet device. Two residents attended day services once a week and the remainder the week was the responsibility of the core staff team. A review of activities of four residents indicated that for some, they had a very limited number of meaningful engagement in community activities.

The premises is a large nine-bedroomed house which was found to be in a good state of repair, warm, clean and tastefully decorated. Residents had ample space in their bedrooms, which were decorated to their personal taste. However, there was a large amount of equipment such as wheelchairs and rollators which had to be stored in the sitting room. This detracted from the homeliness of that space.The inspector found that for one resident who was in the process of transitioning to another residential centre, a detailed plan was in place. It was evident that a significant effort had been made to put a life story book together for the resident to best support them in their new home.

The provider had systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. There was a risk register in place and residents had individual risk assessments on their care plans. However, many of these were found to be out-of-date and required review to ensure that they reflected both the residents' presentation at the current time and public health guidance relating to infection prevention and control. Any adverse events were found to be appropriately documented and reported. There was evidence of learning from these events.

The provider was found to have good measures in place to protect residents and staff in the event of a fire. Detection and containment systems were in place in addition to emergency lighting. Fire fighting equipment was available in the centre. Equipment was checked at regular intervals and serviced regularly. Adapted equipment was available for some residents in the centre such as vibrating alarms under their pillows and flashing lights to ensure they were alerted of an alarm in the event of a fire.

Personal emergency evacuation plans were in place for residents. Fire drills were regularly carried out, with reasonable evacuation times noted for each drill. Some residents told the inspector what they would do in the event of a fire. Fire drills were reviewed by the person in charge on a quarterly basis to ensure any required actions were carried out and that all staff and residents were participating in drills.

## Regulation 10: Communication

Residents in the centre presented with a range of communication support needs. Some residents used speech to communicate, while others used some words with gesture and Lámh signs were also used. Some other residents presented with more complex needs and required staff to be attuned to their body movements, vocalisations and facial expressions to best support them. Communication guidelines and recommendations were in place for those who required them. Some residents had communication passports in place and staff used social stories with residents, where appropriate, to support them to understand routines relating to appointments or transitioning to a new living environment.

Judgment: Compliant

## Regulation 13: General welfare and development

It was evident that residents were well supported with care needs in the house. Two residents were supported to access day services between one and two days of the week in line with their assessed needs. Some residents stated that they would like to be at their day service more, and missed being part of coffee mornings and the advocacy group which had been discontinued during the government restrictions due to the COVID-19 pandemic. Residents were spending large portions of their day in their bedrooms watching television, drawing or playing games on a tablet computer.

Engaging in meaningful activities and community activities was largely the remit of staff. A review of four residents' quality of life activities indicated that each resident was spending a large amount of time in their bedrooms watching television or listening to music. Take-aways and drives also occured at least twice a month, but there was little evidence of any meaningful engagement in community activities in line with residents' needs and expressed preferences. The person in charge reported that staff aim to get each resident out once week. Staff spoken with expressed the wish to be able to get residents out more and as outlined above, this was an issue which both residents and their families had voiced as a concern.

Judgment: Substantially compliant

## Regulation 17: Premises

For the most part, the premises was in a good state of repair. It is a large house and recently had a bathroom refurbished. There were some areas requiring attention such as paintwork being chipped and rusted shower rails. However, these

were on the premises awaiting fitting on the day of the inspection. As previously mentioned, storage was a significant issue in the centre.

Storage was a significant issue which impacted on the homeliness of some areas of the centre. Due to the changing health care needs of the residents, a large amount of equipment was needed for residents. The sitting room was found to have two wheelchairs, a number of boxes of Christmas lights and decorations stacked, a clothes horse and a rollator. In the staff office downstairs, there were two hoists and a large comfort chair stored.

Judgment: Not compliant

## Regulation 25: Temporary absence, transition and discharge of residents

One of the residents was in the process of transitioning to another location within the service. The inspector viewed documentation in relation to the transition and found that this move had been carefully planned with input from family and relevant health and social care professionals. The resident had a beautiful life story book which had been made in addition to easy-to-read information about their new home. A gradual work-up to the move was in progress and was found to be person-centred.

Judgment: Compliant

## Regulation 26: Risk management procedures

The provider had a risk management policy in place which met regulatory requirements. There were systems in place to identify, assess and mitigate against risk in the centre, including emergencies. There was a risk register in place and residents had individual risk assessments on their care plans. However, many of these were found to be out-of-date and required review to ensure that they reflected both the residents' presentation at the current time and public health guidance relating to infection prevention and control. Risks needed to be reviewed to ensure that they were rated proportionately and that they were specific to the needs of the residents in the centre. There was a clear system in place to report any adverse events which occured in the centre. These were found to be appropriately documented and reported. The inspector noted that there had been a number of medication errors in the months prior to the inspection. Incidents and accidents were discussed at staff meetings each month to ensure that any required actions or learning from events took place.

Judgment: Not compliant

## Regulation 28: Fire precautions

The provider was found to have good measures in place to protect residents and staff in the event of a fire. Detection and containment systems were in place in addition to emergency lighting. Fire fighting equipment was available in the centre. Equipment was checked at regular intervals and serviced regularly. Adapted equipment was available for some residents in the centre such as vibrating alarms under their pillows and flashing lights to ensure they were alerted of an alarm in the event of a fire. Adapted equipment was in use to evacuate some residents safely, and staff had received additional training in relation to this.

Personal emergency evacuation plans were in place for residents. Fire drills were regularly carried out, with reasonable evacuation times noted for each drill. Some residents told the inspector what they would do in the event of a fire. Fire drills were reviewed by the person in charge on a quarterly basis to ensure any required actions were carried out and that all staff and residents were participating in drills.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Residents had assessments of needs in place and these informed their care plans. Care plans were easy to navigate and had a traffic light system in place. This ensured that important information about residents was clear to staff. Person-centred plans required review. Some residents had their personal plans on their I-Pad and photographs of the activities they had done. However, documentation in relation to person-centred plans required review. Some plans were not completed in a significant period of time and this did not provide evidence that residents were setting, and indeed achieving their personal goals. There was evidence of residents going to shows on occasion and the staff member on duty was supporting some residents to plan another event in the months following inspection. The person in charge reported that personal plans and goals were not always progressed or achieved due to the impact of staffing levels in the centre.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents were supported to have best possible health in the centre. As previously outlined, the centre was providing a service for a resident who was at end-of-life, while others presented with complex health care needs related to ageing. It was

evident that residents had regular input from their GP and a range of health and social care professionals including occupational therapy, physiotherapy, speech and language therapy and dietetics. There were a range of medical professionals involved in residents' care and a record of appointments attended was kept, with an outcome documented. Documentation of end-of-life care plans had improved since the last inspection. Residents' will and preferences regarding end-of-life care, including do not resuscitate status and transfer to hospital were discussed and clearly documented.

Judgment: Compliant

## Regulation 8: Protection

As previously stated, the provider had a number of policies in place to ensure that residents were protected from all forms of abuse. Documentation of personal care needs and supports placed an emphasis on each residents' right to privacy and dignity during these interventions. Consent was sought from residents on each personal care task in addition to many other areas of their care.

While there were a low level of safeguarding incidents occurring in the centre, the inspector found that documentation was incomplete for incidents which had occured. The inspector was not adequately assured that this was in line with national policy. For example, for one incident there were two safeguarding plans on a resident's care plan. It was unclear whether these were still active or discontinued and therefore, it did not give clear guidance to staff. For another incident, it was not evident what the outcome of a preliminary screening was, and therefore whether a safeguarding plan was required. There was a safeguarding log in place in the centre but information was omitted on one incident and it was unclear whether all safeguarding items were open or closed.

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 | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 13: General welfare and development | Substantially compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 25: Temporary absence, transition and discharge of residents | Compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Navan Road - Community Residential Service OSV-0003062

## Inspection ID: MON-0034611

## Date of inspection: 02/02/2023

**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:<br>A review will be undertaken by the Provider to ensure the WTE's assigned to the centre reflect the needs of the supported individuals. The PIC will review the rosters with the PPIM to ensure the hours of staff are rostered effectively and based on the needs of the supported individuals. The Provider will ensure that planned and unplanned leave will be covered by a cohort of regular relief staff to ensure consistency. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>All staff will receive the required refresher training in line with the Regulations.1/06/23<br>The PIC maintains a training matrix which identifies all training needs within the Centre this will be reviewed regularly by the PIC and PPIM. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and | |

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| management:<br>The Provider will ensure that the PIC is supported to maintain their supernumerary hours And these are clearly reflected on the rosters<br>The PPIM has additional oversight within Centre with weekly visits to the Centre. |

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| Regulation 13: General welfare and development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 13: General welfare and development:<br>All residents are supported to participate in activities based on their will and preference,<br>The PIC has made a referral to source a volunteer to support the individuals to access.<br>The PIC will ensure that there is a shift plan in place which identifies access to activities of choice | |
| Regulation 17: Premises | Not Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>The Providr has met with the PIC and identified all areas within the centre which require maintenance<br>Storage areas have been assessed and additional storage will be added<br>All excess furniture has been removed from the centre | |
| Regulation 26: Risk management procedures | Not Compliant |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>All risk assessments will be reviewed and rated appropriately to reflect the current needs of the residents in the centre.<br>PIC will source additional support from the risk management team.1/06/23 | |

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| 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:<br>All individual assessments will be reviewed and appropriate interventions will be in place based on the needs of the individuals | |
| Regulation 8: Protection | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 8: Protection:<br>All documentation for safeguarding will be reviewed in line with National Policy.The safeguarding log will be updated to reflect all documentation and needs in the centre.<br>1/05/23 | |

## 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 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. | Substantially Compliant | Yellow | 30/05/2023 |
| Regulation 15(1) | The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. | Not Compliant | Orange | 30/05/2023 |
| Regulation 15(3) | The registered provider shall ensure that residents receive | Not Compliant | Orange | 01/06/2023 |

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| | continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | | | |
| Regulation 15(4) | The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained. | Substantially Compliant | Yellow | 30/05/2023 |
| 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 | 01/06/2023 |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Not Compliant | Orange | 30/04/2023 |
| 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. | Substantially Compliant | Yellow | 30/04/2023 |

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| 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. | Not Compliant | Orange | 30/05/2023 |
| 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. | Not Compliant | Orange | 01/06/2023 |
| Regulation 05(6)(d) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments. | Substantially Compliant | Yellow | 30/05/2023 |
| Regulation 08(3) | The person in charge shall initiate and put in place an Investigation in relation to any | Substantially Compliant | Yellow | 01/05/2023 |

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| | incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse. | | | |