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:	Arranmore
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 8
Type of inspection:	Announced
Date of inspection:	19 and 20 January 2023
Centre ID:	OSV-0003591
Fieldwork ID:	MON-0029963

About the designated centre

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

Arranmore is a designated centre operated by St. John of God Community services and is situated on a campus based setting in South Dublin. It is a large one storey property that provides residential services for a maximum of 11 residents. There is one dining area, kitchen, 11 bedrooms, a staff office, a medication room and a TV lounge. There are two accessible bathrooms, two shower rooms and two toilets. There is a small grassy and paved area to the back of the building where residents, staff and family members can sit. There is also access to a swimming pool, day services, an oratory, gymnasium and multi-sensory room located on the campus. Residents are supported 24/7 by nursing staff, healthcare assistants and social care workers. Resident's have access to multidisciplinary supports in the organisation such as; social workers, physiotherapists, occupational therapists, speech and language and psychology, as required.

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
Thursday 19 January 2023	09:50hrs to 17:55hrs	Jennifer Deasy	Lead
Friday 20 January 2023	09:35hrs to 15:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection took place over two days. The inspector had the opportunity to meet most of the residents over the course of the inspection, along with several staff and some family members of the residents. One resident spoke to the inspector regarding their experience of living in Arranmore designated centre. Other residents communicated non-verbally through facial expressions, eye contact and vocalisations.

Information was gathered through interactions with residents, observations of care, conversations with staff and family members and a review of the documentation. This information was used to form judgments on the quality of care being provided in the designated centre. The inspector wore appropriate personal protective equipment (PPE) and maintained physical distancing as much as possible during all interactions.

On arrival to the centre, the inspector saw that it had been painted externally and looked clean and well-maintained. The inspector was greeted by staff who were wearing face masks in line with current public health guidance. The inspector saw that there was availability of hand sanitiser and face masks at the front door. Wall-mounted hand sanitiser was also available at regular intervals throughout the designated centre.

The centre had undergone significant refurbishment works over the past 12 months and this has been outlined in recent inspection reports. Overall, the inspector could see that the centre was clean, well-maintained and equipped with aids and appliances to support accessibility for the residents. Residents each had their own bedroom which was decorated in line with their individual needs and there was sufficient availability of communal space and accessible bathrooms.

Many of the residents had left for day service when the inspector arrived on the first day. The inspector met one resident who was getting ready to go swimming in the community. This resident greeted the inspector by smiling. They appeared comfortable and relaxed in their home. The inspector saw that staff interactions with this resident were gentle and supportive.

Most of the residents returned to Arranmore in the late afternoon. The inspector saw that residents were supported to participate in activities which were meaningful to them and which were in line with their assessed needs. Some residents engaged with sensory toys while others watched television in the sitting room. A few residents went to bed which the inspector was informed was their choice. The inspector saw that soft music and lighting was on in the residents' bedrooms and that they were checked in on regularly by staff.

There was a choice of dinner which had been prepared by a chef for the residents' evening meal. The inspector saw that there were sufficient staff to support the

residents with their meal. The majority of resident and staff interactions during the evening meal were gentle and caring however the inspector saw that one resident was not supported with their meal in a way that best promoted their dignity and autonomy. This will be discussed further in the quality and safety section of the report.

Many of the residents required their meals to be blended in line with their assessed needs. The inspector was informed that each part of the meal was blended separately in order to maintain visual appeal. However, the inspector saw that when meals were reheated, the different foods were mixed together and so the appealing nature of the food was lost.

The inspector spoke to one resident who told the inspector that they were happy in their home and that they liked the staff. They told the inspector that they enjoyed going shopping and out for coffee and that they were supported to do this.

The inspector also had the opportunity to speak to some family members of the residents. Family members told the inspector that they had seen positive changes in the designated centre recently. In particular, they commented on the physical premises works and how these had a positive impact for the residents. Family members also were happy with the enhanced management arrangements however they expressed concern that these would not remain stable as there had been many changes in the past. Family members said that they felt there still remained much that could be done to ensure that residents were in receipt of a quality service, including reducing the reliance on agency staff and ensuring that there was a consistent and reliable staff team in place.

The inspector had the opportunity to speak to several staff over the course of the two days. The inspector found that staff were well-informed regarding their roles and responsibilities. Regular staff also knew the residents well and were well-informed regarding the individual residents' care plans and preferences.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspector found that significant enhancements had been made to the local oversight arrangements in the designated centre and that this was having a positive impact on the quality and safety of care. However, further work was required in order to ensure that the

centre was fully compliant with the regulations. In particular, improvements were required by the provider to ensure that records were maintained appropriately and that policies were revised and were sufficiently detailed to guide staff.

There were clear lines of authority and accountability in the centre. The centre was managed by a suitably qualified and experienced person in charge. They were employed in a full time capacity and were supernumerary to the roster. The person in charge based themselves from the designated centre on a daily basis. The person in charge had oversight of an additional designated centre which was located on the campus. They were supported in their role locally by a clinical nurse manager and social care leader which enabled them to ensure oversight of both designated centres.

The person in charge reported to a service manager. Regular meetings were held between the person in charge and service manager to support oversight of the quality and safety of care.

A staff supervision schedule was in place and all staff had received recent supervision. Regular staff meetings were held. Staff spoken with were aware of the reporting structure. Staff informed the inspector that they felt supported in their roles and were aware of their responsibilities.

Several vacancies in the designated centre had been recently filled and a review of the roster demonstrated that there was a consistent staff team in place with the appropriate skill mix to meet the assessed needs of the residents.

There were a series of audits including six monthly unannounced visits by the provider's quality and standards team. These audits were used to inform a quality enhancement plan for the centre. While the audits looked at compliance with a wide range of regulations, they did not consistently identify gaps in the quality of actions taken in order to comply. For example, the audits did not identify that some care plans were missing or inaccurate in residents' files. It was therefore not evidenced that the audits were wholly effective in driving service improvement.

While some of the records required to be in place, such as the statement of purpose were found to be accurate, others required review and enhancement. These included the Schedule 2 files of staff, the directory of residents and the provider's Schedule 5 policies. The inspector found that most of the policies available in the designated centre were out of date and required review. Additionally, there was no provider specific policy on safeguarding and there was no policy on the provision of information to residents.

Registration Regulation 5: Application for registration or renewal of registration

An application to renew the centre's certificate of insurance was received along with

the appropriate fee within the required time frame.

However, there were several errors in the application form and in the prescribed information submitted which required review by the provider before the application could be progressed. These included:

- incorrect information on the statement of purpose
- inaccurate information in the residents' guide

Judgment: Substantially compliant

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge who was supernumerary to the roster.

The person in charge was suitably qualified and experienced.
They had oversight for an additional designated centre which was located on the same campus as Arranmore.

There were systems in place to support the person in charge in having oversight of both designated centres.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual roster was maintained. A review of these rosters found that staffing levels were in line with the statement of purpose and that the skill mix of staff was suitable to meet the assessed needs of the residents.

The staffing team had been enhanced since the last inspection and several vacancies had been filled.

Nursing care was available to those residents who required it.

The staff files were reviewed. The inspector found that these did not contain all of the information as required by Schedule 2 of the Regulations. Some of the missing information, such as up-to-date certificates of retention with professional bodies, was provided to the inspector before the end of the inspection by the staff. A review of the schedule 2 files is required to ensure that they contain all of the information as prescribed by the regulations.

Judgment: Substantially compliant

Regulation 21: Records

The records maintained in the designated centre required review by the provider to ensure that they contained all of the information as prescribed by the Regulations.

Several key pieces of information were found to be absent from the Schedule 2 staff files. These included:

- A failure to ensure that there were two written references in respect of all staff
- A garda vetting report had not been reviewed since it was first submitted in 2007.
- Several certificates of retention with professional bodies were out of date

The directory of residents also required review. The inspector found that this record was missing information as required by the regulations:

- residents' gender.
- the name of the authority/organisation that arranged admission of the resident to the designated centre.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had effected a contract of insurance against injury to the residents and had insured against other risks in the designated centre including damage to the building.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre was found to be resourced in line with the statement of purpose.

There were clear lines of authority and accountability within the designated centre.

The oversight arrangements had been recently enhanced with the recruitment of

several senior staff members to support the person in charge in fulfilling their regulatory responsibilities.

There were a series of audits in place including six monthly unannounced visits. These informed a quality enhancement plan. However, on review the inspector found that the audits were not consistently identifying gaps in regulatory compliance and in the assessment of the quality and safety of care. The audits were therefore not wholly effective in driving service improvement. Examples of these gaps are further demonstrated under regulation 9: Residents' Rights and Regulation 8: Protection

The inspector also saw that there was a supervision schedule in place for staff and that individual staff were performance managed. However, further work was required to support staff to raise and address concerns identified in relation to the delivery of care on an everyday basis. The inspector observed an example of poor practice in relation to mealtime provision. However, it was not demonstrated during the inspection if the practice issue was brought to the attention of the relevant staff or person in charge in a timely manner. Improvements were required to the arrangements in place for supporting staff in raising and addressing concerns in relation to the delivery care on an everyday basis. This was required in order to ensure consistent promotion of good practice in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was in place and available in the designated centre.

The statement of purpose contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

There was a copy of the provider's Schedule 5 policies maintained in the centre. However, the vast majority of these were out of date and required review. The person in charge attempted to find newer versions of the policies on the provider's intranet but was unable to locate these.

There was no policy on the provision of information to residents.

The provider had not enacted a safeguarding policy and instead relied on the HSE safeguarding vulnerable adults policy. This was insufficient as it did not guide staff

on the local and organisational arrangements for the management of safeguarding risks.

Judgment: Not compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspector found that the centre had made significant progress in enhancing the safety of care in the designated centre. There had been actions implemented in order to enhance the quality of care, and in particular to provide a more person-centred approach. However, further work was required to ensure that the centre was providing rights based care which was in line with national standards.

The inspector saw that the premises was clean and well-maintained. There was sufficient communal space as well as private bedrooms. Resident bedrooms were decorated in line with their individual preferences. Residents were also supported to maintain control over their own possessions and their finances. There was however an absence of a private space for residents to receive visitors aside from their bedroom.

There was a full-time housekeeper who maintained the house in a clean manner and staff also were assigned particular cleaning responsibilities. However, some actions were required to ensure full compliance with the national standards for infection prevention and control in community settings. In particular, staff required further guidance to ensure that care was provided in line with current public health advice and to manage spills of bodily fluids.

The inspector saw that residents had opportunities for education and socialisation. Residents were seen accessing day services and their community for activities which were meaningful to them. Residents were also supported to maintain contact with family members. Family members were seen visiting the centre during the course of the inspection.

The provider had generally taken adequate precautions against the risk of fire. The centre was fitted with measures to detect, contain and extinguish fires. However, the inspector saw that one fire door required enhancement to ensure that it could adequately contain fire and, that there was an outstanding piece of work required to ensure that the attic compartments breeches were addressed.

A sample of resident files were reviewed. All residents' had an up-to-date assessment of need however, in many cases there were insufficient care plans in place for the assessed needs. This included a lack of a care plan for a resident who presented with a behaviour that placed them at risk of abuse. While this behaviour was known to staff and the inspector was informed that there were informal

techniques used to mitigate against this behaviour, this had not been documented. This required review by the person in charge.

Residents had access to appropriate healthcare as per their assessed needs. There were also appropriate practices and procedures in place in relation to the administration, storage and disposal of medications including controlled medications.

The provider had enhanced the quality of the food and nutrition in the designated centre. There were up-to-date feeding, eating, drinking and swallowing care plans. Staff were familiar with these and food was prepared in line with residents' assessed needs. However, the inspector saw that some improvements were required to ensure that food was reheated in a manner that retained it's visual appeal and that further support was required to ensure residents' dignity and autonomy was respected during mealtimes.

The inspector saw that staff had an increased awareness of residents' rights and of person centre planning. For example, staff spoke confidently regarding the importance of safeguarding residents' finances and their personal possessions. Rights awareness checklists were also in place for each resident. However, the inspector saw that further education and support was required to ensure that staff were accurately and consistently identifying barriers to and supports required for full inclusion and participation in society of the residents.

Regulation 11: Visits

There were no visiting restrictions in the designated centre at the time of the inspection.

While there was plenty of communal living space in Arranmore, there was no private area for residents to receive visitors if they wished to do so.

Judgment: Substantially compliant

Regulation 12: Personal possessions

A list of residents' personal possessions was maintained in the designated centre. Residents were supported to retain control of their personal possessions.

Residents' finances were managed in a transparent manner and were audited regularly.

Staff were aware of the importance of safeguarding residents' belongings and

finances.

Judgment: Compliant

Regulation 13: General welfare and development

There was appropriate care and support available to each resident in line with their assessed needs.

Meaningful days for residents were supported in line with their preferences. Many of the residents accessed a day service while others were supported to engage in preferred activities in a more individualised format.

The provider had contracted in several in-house activities including art therapy and massage.

Many of the residents were also seen on the day of inspection to access their community to go swimming, shopping or out to lunch.

Judgment: Compliant

Regulation 17: Premises

The premises had undergone significant work within the past regulatory cycle. The centre was found to be kept in a good state of repair and was clean and suitably decorated.

Residents each had access to their own bedrooms which were decorated in line with their preferences.

Residents also had access to several large communal areas including a sitting room and dining room.

Bathrooms had been refurbished and were accessible to residents and were well-maintained.

Judgment: Compliant

Regulation 18: Food and nutrition

The practices in place in the designated centre in relation to the food and nutrition

provided to residents had been enhanced. There was a full-time chef who was experienced in modifying foods for residents with assessed needs in this area. The inspector saw that meals were available which offered choice and were of good nutritional value. Meals were prepared in line with residents' needs and were presented in a manner which looked appealing. However, the inspector saw that when meals were reheated after the chef had finished their shift, they were often mixed together in other to ensure effective reheating. This reduced the visual appeal of the food.

There were clear care plans in place for each resident relating to their feeding, eating, drinking and swallowing. Residents had access to dietitians and speech and language therapists. The care plans were reviewed and were found to detail the supported required to support residents to maintain their dignity and autonomy during meals including, for example, the use of assistive feeding equipment. The inspector found that, while staff were aware of these recommendations, they were not fully implemented.

Judgment: Substantially compliant

Regulation 20: Information for residents

The provider had in place a resident's guide which included all of the information as required by the regulations. The residents' guide was located in an accessible place in the designated centre.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Two residents in the designated centre were due to transition to a new home in the near future. Transition plans were in the process of being developed in an accessible manner. The residents' representatives were consulted with regarding this transition. The residents were supported to express their will and preference through experiential means and observations. For example, residents were being supported to visit the house which was intended to be their new home and to become familiar with that environment.

Judgment: Compliant

Regulation 27: Protection against infection

The designated centre was seen to be clean, tidy and well maintained.

The person in charge had recently received enhanced IPC training and was the designated IPC lead for the centre.

However, there were several areas which required review to ensure full compliance with regulation 27. These included:

- The IPC policy required review. It was found to be insufficiently detailed in order to guide staff in managing infection prevention and control risks
- Staff knowledge of the management of spills of bodily fluids required enhancement
- Visiting restrictions were imposed during a recent influenza outbreak which were not in line with the current HPSC guidance
- water flushing was in place but was not occurring as frequently as set out by the provider's policy
- there were no questions asked on the colonisation status of residents on discharge from hospital back to the designated centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were generally adequate measures in place to detect and extinguish fires. However, some improvements were required to the fire containment measures in Arranmore. These included:

- A fire audit in October 2021 had identified that there were breeches of the compartments in the attic space. This had not been addressed by the time fo the inspection
- The inspector saw a significant gap between the edge of one fire door and the door frame at the end of a corridor. This required review to ensure that the door would be effective in containing smoke and fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector saw that there were appropriate and suitable practices in place for the ordering, receipt, prescribing, storage, disposal and administration of medications.

Medications were stored securely.

All medications were labeled and administered to the resident for whom they were prescribed.

Out of date medications were segregated and disposed of suitably.

There were clear procedures in place for the storage and administration of controlled medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed approximately a third of all of the residents' files in the designated centre. They were all found to contain an up-to-date assessment of need. However, in many cases, there were insufficient care plans in place for the needs identified. For example, some residents were identified as having communication needs but did not have a care plan in place.

The inspector also found that several of the care plans which were in place were inaccurate or insufficiently detailed. For example a jejunal tube care plan did not accurately detail the correct steps required for this care. Additionally, the inspector saw that referrals were made to clinicians for particular health related issues however care plans were not in place for these needs.

Judgment: Substantially compliant

Regulation 6: Health care

It was evident that residents had access to appropriate multidisciplinary professional as per their assessed needs and that access to these services was provided in a timely manner.

End-of-life care plans were in place which detailed residents' or their representatives preferences for their care at this time.

Judgment: Compliant

Regulation 8: Protection

While the inspector was assured that staff were aware of their safeguarding roles and responsibilities and that incidents of concern were notified to the HSE and to the Chief Inspector, improvements were required to ensure the centre met the full requirements of Regulation 8. These included:

- The provider did not have their own safeguarding policy in place to guide staff specifically in the procedures in place within the organisation to respond to and report incidents of abuse
- The inspector saw one resident engaging in a behaviour which placed them at risk of abuse. This had not been identified as a safeguarding risk and there was no care plan in place in this regard. The impact of this behaviour on other residents had also not been considered.
- The inspector saw that the provider's own audits were ineffective in monitoring the garda vetting status of all staff.
- The most recent six monthly audit focused on reviewing the centre's quality enhancement plan (QEP). The QEP marked that regulation 8 ''safeguarding'' was complete. However, an identified safeguarding risk related to night duty had not been risk assessed and there were no documented safeguarding plans with associated safeguarding risk assessments in place.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While staff had received training in person-centred planning and were aware of the importance of upholding residents' rights, further work was required to ensure residents' rights were consistently upheld in the designated centre.

Rights checklists on files did not identify potential barriers to full inclusivity. Checklists had concluded that residents had full access to all parts of their environment and community. However, due to the complex needs of many of the residents, considerable support was required from staff to enable this. This support was not documented on these rights' checklists

Furthermore, the inspector saw some practices which did not show good awareness of residents' rights to dignity and autonomy. For example, one resident's feeding care plan set out that they could feed and take drinks themselves independently with the correct adaptive equipment. The inspector did not see this equipment available at the mealtime observed. Staff spoken with were aware of this equipment but stated that it was not routinely used.

Additionally, supported feeding by some staff was done in a manner which did not demonstrate an awareness of the supports required to maintain residents' dignity, including for example, having paper towels or napkins available for residents to wipe their hands or face.

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	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Arranmore OSV-0003591

Inspection ID: MON-0029963

Date of inspection: 19/01/2023 and 20/01/2023

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
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: Registration Regulation 5: Application for registration or renewal of registration: Statement of purpose and residents guide to be reviewed in line with regulations and additional information provided as required. This has been completed on 20.02.2023	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All NMBI certs were provided to the inspector on the day of inspection: 19.01.2023 A review of all schedule 2 files will be carried out by 06.03.2023 and identified documentation will be in place no later than 31.03.2023	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All HR files will be reviewed by 06.03.2023 Any staff member's Garda vetting that is expired has been re submitted since 20.01.2023 and personnel files will be updated once returned from GVB	

Directory of residents has been updated since 20.01.2023 with omitted information completed

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
CNM3 will link with the quality team by 28.02.2023 to review audit tools to ensure that they are capturing gaps in regulatory compliance.
CNM3 will discuss with staff, pathways for staff to address concerns regarding delivery of care to ensure consistency. These pathways will be implemented by 28.02.2023. The CNM3 will also deliver specific staff training to support staff in identifying poor practice and raising concerns. The identified training needs will inform the development of an in-service training schedule to be delivered over the year. This plan will be in place by 28th February 2023.Consistency in delivery care will also be a standing item on the agenda at staff meetings from February 2023.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Organizational policies are currently under review, the policies listing developed by the quality team is added as an attachment to the compliance plan. It details the policies currently under review, those that have been extended and the timelines for completion.
The organization has adopted the HSE safeguarding policy. There is a safeguarding statement and a local operation procedure in relation to safeguarding that applies across Liffey region. Staff are aware of the HSE policy, and the organizations approach to safeguarding via regular team meetings and safeguarding training. Safeguarding is a standing agenda item for these meetings
The organization has a policy on Total Communication, this has been placed in the Schedule 5 folder

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
There is a visitor's room planned for development once residents have relocated to Liffey 8. This will be developed to be a small comfortable room where families can visit privately with their loved ones. This will be in place by 30.06.2023

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Staff will be trained in the appropriate ways to support the residents with pureed / blended diet no later than 31.03.2023.
SLT reassessment of one residents needs to support change in his diet has been undertaken on 24.01.2023. The resident's meal plan has been amended to reflect changes in the resident's diet.
All staff to receive support to adhere to the nutritional recommendations.
SLT to provide food molds which will enable the blended meals to maintain the appearance of familiar food. SLT will provide training to staff in the use of the food molds and assistive feeding equipment by 31.03.2023.
This will support the residents in identifying the different components of their meal and encourage staff to feed the residents their meal in a more palatable way

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
IPC policy is under review at organizational level. A local operating policy will be drafted to reflect and support the IPC practices in Arranmore and will be readily accessible for staff to refer to no later than 28.02.2023
All residents have a hospital passport in place which includes a request for information in relation to exposure to multi drug resistant organisms or any other colonization risk during a hospital stay
Staff to receive refresher IPC training which will include management of spills from CNM3 (Link IPC staff) by 31.03.2023.
Water flushing in line with recommendations has commenced since 20.01.2023

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Works to be carried out to remediate the compartments in the attic space and to ensure an adequate fire seal on the door leading into Oak lodge. The attic space is in the process of being assessed for the presence of Asbestos. Works to be complete by 30.06.2023

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:
All care plans and MPP's to be reviewed by 30.06.2023 to ensure that they reflect the needs of the residents.
A schedule is in place for the keyworker to review their residents care plan every three months. This will be audited by the CNM1/CNM3 on a three monthly basis.
There is a schedule to review each care plan at staff meeting to provide an opportunity for all staff to review the care plan and ensure that the care plan accurately reflects the support needs of the resident.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
There is a protocol in place regarding waking night duty and responsibility that has been provided to staff on 20.02.2023.
The roles of staff in identifying and reporting safeguarding concerns to local management to be a rolling agenda item at staff meetings with effect from 20.02.2023.
There is an algorithm available to guide staff on what actions to take should a safeguarding concern arise during the shift.
HR is currently undertaking a Garda vetting Audit. Any staff member's Garda vetting that is expired has been re submitted since 20.01.2023and personnel files will be updated once returned from GVB

The HSE National Safeguarding policy and the SJOG organizational statement in relation

to safeguarding is in the Schedule 5 folder.
The roles of staff in identifying and reporting safeguarding concerns to local management to be a rolling agenda item at staff meetings with effect from 20.02.2023.
There is an algorithm available to guide staff on what actions to take should a safeguarding concern arise during the shift.
There is now a care plan in place for the resident engaging in behavior which placed them at risk. This was put in place on 20.01.2023. A safeguarding report has been completed along with a PSF1 and there is now a safeguarding plan in place to ensure the safety of this resident and those who may be impacted by his behavior.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Staff to receive training in person centered planning, care provision and rights-based approach to service delivery by 30.06.2023.
CNM1 and CNM3 to provide on site support where practices are observed to be below the expected standard
All staff to complete the HSELand training on Applying a Human Rights Based Approach In Health And Social Care no later than 30.06.2023.
Rights checklist to be amended by 30.06.2023
All the residents have the correct assistive feeding equipment in place and staff are aware of how to use this appropriately since 20.01.2023. The residents care plans include information about their assistive feeding equipment needs.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	28/02/2023
Registration Regulation 5(3)(f)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by a copy of the written guide produced for residents in accordance with Regulation 20 of the Health Act	Substantially Compliant	Yellow	28/02/2023

	2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and an example of any brochure or advertisement used or to be used for the designated centre.			
Regulation 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident’s room, is available to a resident in which to receive a visitor if required.	Substantially Compliant	Yellow	30/06/2023
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/03/2023
Regulation 18(2)(a)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and	Substantially Compliant	Yellow	31/03/2026

	safely prepared, cooked and served.			
Regulation 18(3)	The person in charge shall ensure that where residents require assistance with eating or drinking, that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.	Substantially Compliant	Yellow	31/03/2023
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/03/2023
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/06/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an	Substantially Compliant	Yellow	30/03/2023

	unannounced visit to the designated centre at least once every six 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	28/02/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures	Substantially Compliant	Yellow	31/03/2023

	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	30/06/2023
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/06/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/06/2023
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	Substantially Compliant	Yellow	30/06/2023

	reflects the resident's needs, as assessed in accordance with paragraph (1).			
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	30/06/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	28/02/2023
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	30/03/2023
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature	Substantially Compliant	Yellow	30/03/2023

	of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	30/06/2023