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:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Dublin 10
Type of inspection:	Short Notice Announced
Date of inspection:	04 May 2021
Centre ID:	OSV-0003730
Fieldwork ID:	MON-0032462

About the designated centre

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

The centre is based in Dublin and operated by the Health Service Executive. It consists of one building, within a hospital campus. Care and support is provided for up to seven adult residents, both male and female with a physical, sensory or neurological disability. At the time of inspection there were no vacancies in the centre. The building comprised of seven large bedrooms with ensuite facilities. There is also a large sized day room, family room and industrial styled kitchen. Support is provided for residents over a 24 hour period by registered nurses and healthcare assistants. The person in charge is supported by a clinical nurse manager (CNM) 2 and a CNM 1.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 - 2015 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
Tuesday 4 May 2021	9:30 am to 4:00 pm	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what the inspector observed, there was evidence that the residents living in the centre received high quality medical care and support. As identified on previous inspections, the centre operated a largely medical model of care. Commitments had been made to the office of the chief inspector that a social model of care would be embedded in the centre. An external company had been sourced to support the centre to incorporate a social model of care. The work of the external company had been delayed due to constraints outside the control of the provider. Therefore, although some improvements had been made in the preceding period, further improvements were still required to ensure that appropriate social care was being provided for each of the residents. Other areas for improvement were identified in relation to the premises, personal support plans, communication supports, fire safety, staff training and supervision.

The centre had originally comprised of two separate units, the Elm and Lisbri units and was registered for a total of 26 adult beds. However, in 2020 the provider reconfigured the service and applications to vary the conditions of registration were granted. This resulted in the foot print of the centre being reduced from two to one unit (the Elm Unit) and the number of residents accommodated being reduced to seven. A separate registration application from a new provider to become the registered provider for the other unit (Lisbri) was also granted. One resident from the Lisbri unit, had transitioned to this centre in 2020 whilst two residents from this centre had transitioned to the Lisbri unit. These transitions had been assessed to be appropriate so as to better meet the individual resident's needs. Each of the residents had been living within the campus for an extended period.

Since the last inspection, the service had been reconfigured and a new person in charge and management team had been appointed. Previously, a number of residents had shared bedrooms but with the reconfiguration of the service, each of the residents now had their own spacious en-suite bedroom. The provider had a history of non-compliances and had been engaged in an escalated process with the office of the chief inspector. There were notable areas of improvement which it was considered impacted positively on the quality of life for residents. Appropriate governance and management systems had been put in place and monitoring of the services provided had been completed, in line with the requirements of the regulations.

The centre comprises of a seven bed roomed unit on a hospital based campus. Residents living in the centre ranged in age from 50 to 78 years and six of the seven residents had been living in the centre for a prolonged period. A largely medical model of care was being operated and registered staff nurses were on duty at all times to meet the residents' care and support needs. A medical director and medical officers were accessible on campus.

Over the course of the inspection, the inspector met briefly with each of the seven

residents. Warm interactions between the residents and staff caring for them was observed. A number of the residents were unable to tell the inspector their views of the service but they appeared in good form and comfortable in the company of staff. Two of the residents told the inspector that they were happy living in the centre and that staff were kind and helpful to them.

There was an atmosphere of friendliness in the centre. Cheerful music was heard playing on the day of inspection. A number of residents were heard conversing with staff who responded well to their verbal and non verbal cues. Numerous photos of residents were on display. Staff were observed to interact with residents in a caring and respectful manner. For example, a staff member was observed providing a resident with a hand massage which they appeared to enjoy. Signs were noted on bedroom and bathroom doors to alert others when care was being delivered.

As identified in previous inspection reports, the centre had an institutional feel. However, some efforts had been made to give the centre a more comfortable and homely feel. Each of the residents had complex medical needs which necessitated the use of a various pieces of medical equipment. An environmental review had recently been undertaken by the provider and identified a number of areas for improvement and maintenance upgrades. This included the establishment of a sensory room. On this inspection, worn and chipped paint was observed on some walls and woodwork. Flooring in a number of bathrooms appeared worn. Each of the residents had their own spacious bedroom with en-suite facility. Residents' bedrooms had been personalised with personal photos and some other items of their choosing. This promoted residents' independence and dignity, and recognised their individuality and personal preferences. The centre had adequate space for residents with good sized communal areas. There was a dining come day room area and a separate large family room. An industrial style kitchen was in place but all cooked meals were prepared in a separate kitchen within the campus and transported to the centre. There was a private patio and garden area to the rear of the centre. However, it was noted that the garden was in need of maintenance and further development. There were some flower pots and a bird feeder on display.

Residents had access to advocacy services should they so wish. Staff had received some training on a rights based approach to care. A dignity 'do's and don'ts' poster was on display for staff reference. There was information on rights and advocacy services available. The charter of rights was detailed in the residents guide. There was evidence of consultations with residents regarding their care and the running of the centre. Residents' meetings were completed on a regular basis and these were chaired by one of the residents with the support of staff.

There was evidence that residents and their representatives were consulted with and communicated with, about decisions regarding their care, the running of their home and the recent reconfiguration of the centre. Each of the residents had regular one-to-one meetings with their assigned key workers. Residents were supported to communicate their needs, preferences and choices at these meeting in relation to activities and meal choices. However, it was noted that the majority of residents were non verbal and that there was limited communication supports available. The inspector did not have an opportunity to meet with the relatives or representatives

of any of the residents but it was reported that they were happy with the care and support that the residents were receiving. The provider had completed a survey with some relatives which indicated that they were happy with the care being provided for their loved ones.

Residents were supported and encouraged to maintain connections with their friends and families through a variety of communication resources, including video and voice calls. With the lifting of COVID-19 restrictions, some visiting was being re-established which was in line with national guidance. Window visits were also being facilitated. One of the residents told the inspector that the resumption of some visiting in the centre had been welcomed. There was a daily postal delivery to the centre.

Residents were supported to engage in some but limited meaningful activities in the centre. In line with national guidance regarding COVID-19, the centre had implemented a range of restrictions impacting residents' access to activities in the community. An additional staff member had been rostered on duty during the day to support residents to engage in activities of their choosing. Examples of activities that residents engaged in included, foot and hand massage, story reading, watching television, listening to radio, personal grooming treatments, walks within the hospital campus, bird feeding and some board games. A weekly schedule of activities was displayed on the notice board in the staff office but it was noted that some of the activities listed were not being undertaken. This schedule was revised on the day of inspection. It was proposed that with the lifting of restrictions, access for residents to meaningful activities in the community would be supported. The centre did not have its own dedicated vehicle but could avail of a vehicle used by another service on the campus. It was reported that a vehicle for the sole use of residents in the centre was planned.

The majority of the staff team had been working in the centre for an extended period. This meant that there was consistency of care for residents and enabled relationships between residents and staff to be maintained. Each of the residents had two assigned keys workers, one being a registered nurse and the other a healthcare assistant. The inspector noted that residents' needs and preferences were well known to staff, the clinical nurse manager and the person in charge.

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

Capacity and capability

Since the last inspection, a new management structure, systems and processes had been put in place to promote the service provided to be safe, consistent and appropriate to residents' needs. However, some areas for improvement were identified in relation to staff training and supervision and the oversight of identified

service improvement areas.

A new person in charge was appointed to the centre in November 2020 who was suitably qualified and experienced. He had a good knowledge of the assessed needs and support requirements for each of the residents. The person in charge held a masters in palliative care and a diploma in healthcare management. He had more than nine years management experience. He was in a full time position but also held nursing administrative role covering the entire campus. He was found to have a good knowledge of the requirements of the regulations. The person in charge reported that he felt supported in his role and had regular formal and informal contact with his manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge was supported by a clinical nurse manager grade 2 (CNM 2) and CNM 1. The person in charge reported to the director of nursing who in turn reported to the general manager for disabilities. The person in charge and director of nursing held formal meetings on a regular basis.

The provider had engaged with an external company to undertake quality reviews and to support the provider to embed a social care model within the medically oriented unit. The work of the external company had been delayed due to constraints outside the control of the provider. A service improvement plan was in place. However, it was noted that some proposed timelines and actions had not been completed. The CNM2 had completed weekly quality and safety walk arounds. The provider had completed an annual review of the quality and safety of the service and unannounced visits, to review the safety of care, on a six monthly basis as required by the regulations. A number of other audits and checks had also been completed. Examples of these included, infection prevention and control, hand hygiene, care plan, medications, health and safety checklist, complaints and audit of pressure sores. There was evidence that actions were taken to address issues identified in these audits and checks. There were regular staff meetings and separately local manager and senior management meetings with evidence of communication of shared learning at these meetings.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. At the time of inspection, two members of the staff team were on long term leave. This was being covered by a small number of regular agency staff. This provided consistency of care for the residents. The actual and planned duty rosters were found to be maintained to a satisfactory level.

Some training had been provided to staff to support them in their role and to improve outcomes for the residents. However, a number of staff required refresher training in mandatory areas. There was a staff training and development policy. A training programme was in place and coordinated by the provider's education and training officer. There were no volunteers working in the centre at the time of inspection. Staff supervision arrangements were in place. However, it was noted

that supervision was not being undertaken in line with the frequency proposed in the providers policy. This meant that staff may not have been adequately supported to perform their duties to the best of their abilities.

A record of all incidents occurring in the centre was maintained and overall where required, these were notified to the Chief Inspector, within the timelines required in the regulations.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. There was a consistent team of staff working with the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Some training had been provided to staff to support them in their role and to improve outcomes for the residents. However, a number of staff required refresher training in mandatory areas. For example, safeguarding and restrictive practices. Staff supervision was not being undertaken in line with the frequency proposed in the providers policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

Suitable governance and management arrangements had been put in place. However, a number of time lines and actions in a service improvement plan

submitted to the office of the chief inspector had not been reached and completed.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the office of the chief inspector in line with the requirements of the regulations.

Judgment: Compliant

Quality and safety

The residents living in the centre appeared to receive medical care and support which was of a good quality and person centred. However, improvements were required regarding the residents social care needs, resident's communication needs, upkeep of the premises, fire safety and procedures in place to review individual person centred plans.

Residents living in the centre had complex medical needs. Overall, the residents' medical needs and welfare was maintained by a good standard of evidence-based care and support. Personal support plans reflected the assessed needs of individual residents and outlined the support required in accordance with their individual health and personal care needs. However, an annual personal plan review for each of the residents had not been completed in line with the requirements of the regulations. A user friendly version of the personal plan was not available as required by the regulations.

A significant number of the residents were non verbal. Some information on their communication needs were highlighted in personal plans. However, this information was not always clear and there were limited communication tools available, such as pictures or objects of interest, to assist residents to choose diet, activities and daily routines. A notice board in the day room displayed the names of staff on duty but it was reported that plans were in place to display pictures of staff. It was noted that the provider had recently appointed a new speech and language therapist. A referral had been submitted for all of the residents and an assessment had commenced with one of the residents. It was observed that staff responded well to residents non verbal prompts.

The health and safety of the residents, visitors and staff were promoted and protected. Individual and environmental risk assessments had been completed and were subject to regular review. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were

arrangements in place for investigating and learning from incidents and adverse events involving the residents. Trending of all incidents was completed on a regular basis. This promoted opportunities for learning to improve services and prevent incidences.

Precautions were in place against the risk of fire. However, a recent audit completed by an external fire safety consultant identified a number of areas for improvements in relation to the upgrading of fire doors and compartment walls to comply with required standards. Fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks. There were adequate means of escape. A procedure for the safe evacuation of residents in the event of fire was prominently displayed and a fire assembly point was identified in an area to the front of the centre. Each of the residents had a personal emergency evacuation plan which adequately accounted for the mobility and cognitive understanding of the individual resident. Fire drills involving the residents had been undertaken and it was noted that the centre was evacuated in a timely manner.

The provider had implemented a contingency plan for the COVID-19 health emergency which was in line with national guidance. There were procedures in place for the prevention and control of infection. The provider had an outbreak control team and Microbiologist on-site to offer support and review the arrangements in place. The inspector observed that areas appeared clean but as referred to above some surfaces were worn which meant that these areas could be more difficult to clean. There were full time household staff in place who were responsible for cleaning. A cleaning schedule was in place which was overseen by the person in charge and CNM2. Colour coded cleaning equipment was available. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. Specific training in relation to COVID-19, proper use of personal protective equipment and effective hand hygiene had been provided for staff. Staff and resident temperature checks were being taken at regular intervals and on all entries and exits from the centre. Disposable surgical face masks were being used by staff whilst in close contact with residents, in line with national guidance.

There were measures in place to protect residents from being harmed or suffering from abuse. However, it was noted that a number of staff were overdue to attend refresher training in this area. There had been no allegations or suspicions of abuse in the preceding period. Appropriate arrangements were in place to report and respond to any safeguarding concerns. The provider had a safeguarding policy in place. Intimate care plans were on file and these provided sufficient detail to guide staff in meeting the intimate care needs of the individual residents. Residents were provided with appropriate emotional and behavioural support and their assessed needs were appropriately responded to. Residents did not routinely present with behaviours that challenge. There were a small number of physical restrictions in place and these were subject to regular review.

Regulation 10: Communication

Improvements were required to ensure that the residents' communication needs were met. Some information on individual resident's communication requirements were highlighted in personal plans. However, this information was not always clear and there were limited communication tools available, such as pictures or objects of interest, to assist residents to choose diet, activities and daily routines.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents were supported to engage in some but limited meaningful and interesting activities in the centre. Since the last inspection, an additional staff member had been rostered on duty during the day to support residents to engage in activities of their choosing. An external company had been sourced to support the centre to embed a social care model of care. However, although the work of this company had commenced it had been delayed due to constraints outside the control of the provider. A weekly schedule of activities was displayed on the notice board in the staff office but it was noted that a significant number of the activities listed were not being undertaken. This schedule was revised on the day of inspection.

Judgment: Not compliant

Regulation 17: Premises

An environmental review had recently been undertaken by the provider and identified a number of areas for improvement and maintenance upgrades. This included the establishment of a sensory room. On this inspection worn and chipped paint was observed on some walls and woodwork. Flooring in a number of bathrooms appeared worn. The garden area was in need of maintenance and further development.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with a nutritious and varied diet. Meals were prepared in a kitchen located on the campus and transported to the centre. A choice of meal

options were available and residents were consulted with regarding their meal choices. A range of healthy and nutritious snacks were available for residents to access in the centre's kitchen.

Judgment: Compliant

Regulation 26: Risk management procedures

The health and safety of the residents, visitors and staff were promoted and protected. There was a risk register in place, and environmental and individual risk assessments had been completed. Incident reports were completed and reviewed on a weekly basis. A quarterly review of all incidents across the wider organisation were undertaken at the provider's incident review group.

Judgment: Compliant

Regulation 27: Protection against infection

There were suitable procedures in place for the prevention and control of infection which were in line with national guidance for the management of COVID-19. The centre had dedicated household staff who provided cleaning services. A cleaning schedule was in place and the centre appeared clean. A COVID-19 contingency plan was in place which was in line with the national guidance.

Judgment: Compliant

Regulation 28: Fire precautions

A recent audit completed by an external fire safety consultant identified a number of areas for improvements in relation to the upgrading of fire doors and compartment walls throughout the centre so as to comply with required standards.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' well being and welfare was maintained by a good standard of evidence-based care and support. Individual support plans reflected the assessed needs of

the individual resident and outlined the support required in accordance with their individual health, personal and social care needs and choices. Quality of life gap analysis had been completed with the aim to minimise the impact of COVID-19 restrictions on residents lifes.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs appeared to be met by the care provided in the centre. Residents were supported by registered general nurses and healthcare assistants at all times. Medical cover was provided by a medical director and three medical officers who were based on the campus. There is a dedicated occupational therapy and physiotherapy resource. Referrals could also be made to dietetics and speech and language therapy as required. Individual health assessments and plans were in place. There was evidence that dietary guidance for individual residents was being adhered to.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents appeared to be provided with appropriate emotional support. Residents in the centre did not routinely present with behaviours that challenge. There were a small number of physical restrictions in use and these were subject to regular review.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. However, a small number of staff were due to attend refresher training in safeguarding. There had been no allegations or suspicions of abuse in the preceding period. Intimate and personal care plans were in place and provided a good level of detail to support staff in meeting individual resident's intimate care needs. Safeguarding information was on display and included information on the nominated safeguarding officer.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Cherry Orchard Hospital OSV-0003730

Inspection ID: MON-0032462

Date of inspection: 04/05/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All Staff will be 100% compliant in Safeguarding by the 31/07/2021. Training is available on HSEland but onsite training will be provided additionally to enhance compliance. Two new MAPA (management of Actual or potential aggression) trainers have been trained externally for three days starting on the 16th June. This brings the total number of trainers to four which will significantly improve compliance and additional sessions are being run in July and August to address shortfalls in this area due to the pandemic. A survey on Elm Staff about their knowledge and experience in social care was conducted by an external agency in April 2021. Outcome of this survey identified training requirement for Elm Staff. Trainings include Right Based Approach (RBA), Assisted Decision Making (ADM), and Supported Self-Directed Living (SSDL). RBA and ADM will be completed by each staff via HSELand by end July 2021. SSDL training will be provided by external agency by end of August 2021. A yearly supervision calendar is now in place. All staff members receive supervision every 3 months. A copy of their supervision records are kept in a locked cabinet in Elm Unit office. Original copies are also kept in Nursing Administration Building.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
All actions in the Service Improvement Plan 11/2020 are completed except for Discovery process, and staff training identified following staff survey which are currently ongoing.

Service review and Environmental review were completed in May 2021. Action plan of these reviews was generated and brought up to appropriate teams/group for follow-up. Weekly Environmental Group meeting, Fortnightly Local Management Meeting, Monthly Project Group, and Oversight/Provider Meeting, and 6-weekly Social Care Implementation Group meeting are in place to ensure all actions and timelines are monitored.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
Referrals were made to Speech and Language Therapy on the 20th of April 2021. SLT Assessments commenced on 26th of April 2021.
Outcome of these assessments indicate levels of communication of our Residents in Elm:
• Independent communication skills
• Verbal communication with specific supports,
Some residents communicate verbally with some specific supports as outlined in their communication guidelines. Only two of these residents are able to access pictures, objects of reference or photographs to support their receptive language skills. SLT is working with the staff in Elm to advise on suitable supports that can be put in place to maximise the communication skills of these residents' e.g. picture menu's, objects of reference. One assessment remains ongoing as further assessment is required for suitability of a communication aid
• Non-verbal communication
Some residents in Elm communicate non-verbally. Due to the significant cognitive overlay of these residents they are unsuitable for any high tech Alternative and Augmentative Communication Systems. These non-verbal residents also present with visual difficulties which means accessing visual communication supports e.g. writing, drawing, pictures, objects of reference or photographs ineffective. These residents benefit from personalised communication guidelines which maximise their auditory/touch skills.

Speech and Language Therapy has introduced a "communication access" symbol system to Elm. This signage system is used to preserve the privacy and dignity of our residents by using this discrete symbol to help identify those residents who present with a communication difficulty and who need extra supports to communicate. This signage system directs the communication partner to a member of staff who can relay the communication guidelines present in the patients' medical/nursing notes. Details of what supports work best for each resident can be found in his/her communication guidelines.

Some changes have been implemented following HIQA inspection. Staff notice board has photographs of staff on duty which is updated on daily basis. Main activity of the day is displayed in the day room in picture format. A pictured menu for the week is currently being created and will be finalised by end of June 2021. This menu will include hot drinks and refreshments available in the unit. If residents have a specific request outside the menu it will be facilitated.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A weekly activity schedule is now available for residents since 01/06/2021. This schedule incorporates residents preferred activities. The schedule is updated weekly.

A daily group activity is available in the day room. Residents can opt in or out on this activity.
Transport is now available to residents via an external agency specific for social outings.

One staff member has agreed to take up Massage course which will benefit all the residents. This course will commence from September 2021. In the meantime, a massage therapist is currently being sourced via external agency.

An Art therapist is working with our residents once a week commencing in the week of 21/06/2021.

A dedicated staff member from the Activities Department has been allocated to Elm Unit commencing 23/06/2021. This staff member will ensure the weekly activity schedule is in place and implemented on a daily basis.

In May 2021, a private company loaned to Elm residents a wide variety of books, sensory materials, and assorted albums for trial. Staff and residents have identified relevant and appropriate materials for residents to purchase.

An external company is currently working on discovery process for each resident. This process may take up to 3-6 months. MDT individual meetings with residents are happening every 6 months. Via discovery process and MDT individual meeting, residents' goals and wishes will be identified. Activity staff, and Elm Unit care team will ensure goals are met. This will be an ongoing basis.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
There is a very active Environmental subgroup working on improving Elm's physical environment. This group meet on a weekly basis and will be finalising the Environmental report on 24/06/2021. This report will be submitted to Disability Senior Management for approval.

For all environmental changes, residents and residents' advocate are being consulted. They are all encouraged to participate and to let their wishes be known.

Works for a sensory room is currently in progress. An area for snoezelen equipment has been identified. Maintenance department committed to transfer the equipment from Lisbri Unit to Elm by 15/07/2021.

The CNM1, Provider Nominee, and Maintenance Manager met on 01/07/2021 to have a walk about in Elm and agreed that painting and some parts of the flooring needs to be refurbished. This is in progress.

A maintenance log is in place since 10/05/2021. It is kept in Elm Unit office.

A maintenance log is in place since 10/05/2021. It is kept in Elm Unit office.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire and safety officer has commenced procurement process for improvement work that needs to be completed in Elm. It is aimed to be completed by end of Q4 2021.

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:
External company is currently working on discovery process for each resident. This process may take up to 3-6 months. MDT individual meetings with residents are

happening every 6 months. Via discovery process and MDT individual meetings, residents' goals and wishes will be identified. Activity staff, and Elm Unit care team will ensure goals are met. This will be reviewed in a regular basis.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: All Staff will be 100% compliant in Safeguarding by the 31/07/2021. Training is available on HSELand but onsite training will be provided additionally to enhance compliance.

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 10(3)(b)	The registered provider shall ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.	Substantially Compliant	Yellow	31/12/2021
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	23/06/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a	Substantially Compliant	Yellow	31/08/2021

	continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2021
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	31/12/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2021
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or	Not Compliant	Yellow	31/10/2021

	her representative.			
Regulation 05(6)(b)	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 be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	31/12/2021
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/07/2021
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding	Substantially Compliant	Yellow	31/07/2021

	residents and the prevention, detection and response to abuse.			