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:	St. John of God Kildare Service DC 11
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	11 August 2022
Centre ID:	OSV-0004137
Fieldwork ID:	MON-0028218

About the designated centre

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

DC 11 is a residential service operated by St. John of God Services and is located in a large town in Co. Kildare. The designated centre is comprised of two detached houses in a housing estate, next door to each other. Both properties are a two storey building, building one has capacity for three residents and building two has capacity for five residents. Building one has been adapted to meet the accessibility needs of residents. DC 11 supports eight male residents with an intellectual disability by a team of; social care workers, a social care leader and a person in charge. Staffing levels are based on the needs at each location. Some residents have the support of staff sleeping over; while other residents have the support of staff dropping in to their home to provide specific supports like assistance with cooking/sorting out domestic bills/support with safety checks. Residents have access through a referral system for the following multi-disciplinary supports; psychology, psychiatry, social work. All other clinical supports are accessed through community based primary care with a referral from the individuals G.P. as the need arises. There is also an accessible vehicle for residents use in accessing the community along with well serviced public transport.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 11 August 2022	09:45hrs to 18:00hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This was an announced inspection to monitor the provider's progress with their submitted compliance plan arising from their previous inspection in January 2022 and to inform the decision to renew the designated centre's registration. The residents, family representatives and staff team were informed in advance of the planned inspection.

The designated centre is located in a housing estate in a large town in Co. Kildare. The designated centre is comprised of two detached houses in a housing estate, situated next door to each other. Both properties are two-storeys; building one has the capacity for three residents and has been adapted to meet the accessibility needs of residents, and building two has the capacity for five residents.

During this inspection, the inspector met with six residents, staff members, the team leader and with the person in charge of the service.

The residents told the inspector that they felt comfortable and safe in their homes, and the inspector noticed a relaxed and pleasant atmosphere. There was a friendly atmosphere between residents and staff, and residents were encouraged to wake up early or sleep in late, depending on their preferences and their plans for the day. The Health Information and Quality Authority (HIQA) inspections were well-known to the residents. They invited the inspector into their homes, offered them coffee and conversation, and proudly gave a tour of their homes.

One resident met with the inspector and provided them with an update on changes that had occurred since the previous inspection, including premises improvements, new equipment purchased and reductions in public health restrictions. The resident further stated that there had been some changes in staff, but they were happy with the team but expressed their concern regarding the staffing levels and felt that residents could do with additional support in some areas. The inspector also received six questionnaires completed by residents about the quality of care and support that residents received in their homes. Overall the feedback provided was positive; however, four residents did mention more staffing as an area for improvement.

A second resident returned to the house after being out and greeted the inspector as they went into their bedroom. They used a key to open their bedroom door and locked it again when they left their bedroom, which ensured residents' right to privacy was respected when they were not present in their house. The inspector met with three residents in the second house. Residents in this house had higher levels of independence and did not always require the support of staff for many of their activities. While residents' needs differed in their requirement for staff support, the inspector found residents' preferences and needs indicated a higher level of staffing hours than those currently available.

The statement of purpose outlines the ethos as providing support in a manner promoting independence based on individual needs. For example, some residents have the support of staff 24 hours a day, sleeping over in the house. In contrast, other residents have the support of staff dropping into their home a few hours a day to provide specific support like assistance with cooking, safety checks and cleaning. This support is based on identified needs and abilities through relevant assessments. Over the previous year, the collective needs of residents had changed, resulting in a greater necessity for staff input as identified through increased incident and accident reports and communicated directly by residents and staff in the centre. The provider was aware of this increased staff requirement and had applied for increased funding in order to meet the needs of residents, as previously reported in the last inspection of January 2022. However, at the time of this inspection, staffing levels had remained the same. Due to the uncertainty of securing funding, the inspector requested further assurances from the provider for submission post-inspection, as discussed later in the report.

During this inspection, staff members who interacted with inspectors demonstrated a good, personal understanding of each resident, their interests, hobbies, history, and assessed requirements. Staff members were kind, understanding, and reassuring in their interactions with residents. When offering residents refreshment options, for instance, staff were aware of residents' preferences. The support plans of the residents were well-known to the staff, and if further information was needed, they knew where to look.

There was strong evidence that residents were consulted with and communicated with about decisions regarding their care and the running of their homes. For example, each of the residents had regular one-to-one meetings with their assigned key workers. Residents were enabled and assisted in communicating their needs, preferences and choices at these meetings in relation to activities, goals and aspirations. In addition, regular 'Speak up meetings' occurred between residents, which informed residents of changes to staff and public health restrictions and provided information and guidance regarding the operations of the centre, such as fire safety measures and financial contributions. Other topics discussed at these meetings included health and safety, infection control, advocacy, compliments and complaints. Residents were provided realistic information on the speed at which restrictions would be lifted during the pandemic and were kept updated on changes. Residents commented on their enjoyment of preferred activities and social opportunities being available to them again.

Complaints records relating to this house were reviewed, and there was evidence that residents were facilitated to raise complaints. For instance, it was noticed that a resident had recently voiced dissatisfaction with the centre's provision of a certain aid. The inspector was subsequently informed that the complaint had been escalated to stage two of the complaints process in line with the provider's policy as it could not be resolved at a local level. Speaking with the resident, they appeared satisfied that their complaint was being taken seriously and was aware of their rights under the complaints procedure.

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 has self-identified that some improvements were required with how family representation feedback could be better captured as part of the centre's annual review as legally required.

The inspector observed the two houses to have a homely atmosphere with many photographs throughout the centre of residents enjoying various activities with their friends and family. Overall, the layout of the houses met the needs of the residents. Premises issues identified on the previous inspection, for the most part, had been actioned and completed with further works planned. One house was being painted internally in several rooms during the inspection, and residents told the inspector how they contributed to the colour scheme and chose their own colours for their bedrooms.

The inspector found that the residents were encouraged to participate in local community activities and use natural support networks in the community to help develop interests. Through the 'Personal Outcome Measures' (POMS) process, each resident was supported and facilitated to connect with and live in their community in a way that meets their preferences around social activities, hobbies and leisure interests. For example, residents were supported to attend various day programmes provided by St. John of God Kildare Service. Some residents chose to attend these structured day programmes on a part-time basis, and were supported by staff in the centre to participate in activities in their local community or home on the days they have chosen not to attend. One resident has chosen not to attend any structured setting during the day, choosing to participate in various activities with the support of staff in their home during the day. A number of residents were also in paid employment in the local area, supported by the organisation's job coach; these included workplaces such as local shops, garages and a brewery.

Although the inspector found that each resident's wellbeing and welfare was maintained to a good standard, the inspector found that significant improvements were required to the centre's staffing arrangements to ensure that the service was meeting the assessed needs of residents. This will be discussed in the subsequent sections of this report.

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

Capacity and capability

This centre was last inspected in January 2022, when the inspector had identified mixed levels of adherence to the regulations, including staffing, training and the management of complaints. In response to these findings, the provider submitted a

specific compliance action plan that would address these areas. Based on the findings of this inspection, there was increased oversight of this designated centre which contributed to improved compliance levels in some areas. However, as previously mentioned, improvement was still required in relation to the staffing level maintained in the centre.

Since the last inspection, a planned change of person in charge had occurred shortly. The purpose of the changed management reconfiguration was to ensure greater governance and oversight arrangements to ensure positive outcomes for residents and continued good quality care and support. As a result, the regulatory remit of the person in charge had decreased from four designated centres to three. However, at the time of the inspection, the person in charge was temporarily responsible for a fourth centre due to an unplanned absence. The inspector was informed that this additional responsibility was due to cease with the appointment of a new person in charge. It was not found, though, that their current remit was having a negative impact on the running of the current centre. It was noted that the person in charge, supported by a social care leader, was present in the centre regularly, carried out their own audits of the centre on a regular basis and during this inspection, demonstrated a good understanding of the residents and the operations of the centre.

The inspector found many examples of suitable and effective governance and reporting systems in place. Management were kept aware of incidents and ongoing risks through comprehensive reporting of adverse events. Detailed audits on the quality and safety of the designated centre had taken place by the social care leader and the person in charge. Where improvement to regulatory compliance or adherence to provider policy was identified, a time-bound action plan was set out to improve or enhance the quality of service.

The person in charge, supported by the social care leader, reported to the programme manager, who in turn reported to the regional director. The person in charge, the social care leader and the programme manager, held formal review meetings on a monthly basis which promoted effective communication across the centre and ensured the changing needs of residents were escalated to the provider.

The provider had carried out an annual review of the quality and safety of the centre, and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis. The quality and safety adviser conducting these service reviews spoke with residents or observed their support delivery to reflect on their experiences and activities as part of their report. These were found to be of high quality and reviewed specific regulations in detail, providing a quality action plan for any areas that required improvement; this included the provision of appropriate staffing.

The inspector reviewed records related to the supervision and training of the front-line staff members in their roles in supporting residents. Training needs were identified for this designated centre based on mandatory and resident specific training such as diabetes and epilepsy. Staff were supported to stay up-to-date on

their required competencies.

Overall, it was evident that management systems in place ensured that residents were provided with a safe service. This had a positive impact on the quality of care and support that residents received in their homes. It was clear that the provider had identified the need for additional staffing and had escalated this to the funder. However, as the provider could not provide an update on the approval for additional funding or if this funding could be secured, the inspector issued an urgent action during the inspection based on this continued uncertainty. This is discussed in further detail under Regulation 15: Staffing.

Registration Regulation 5: Application for registration or renewal of registration

The provider had effective systems in place to ensure they complied with the requirements to renew their application and had submitted all required documentation in a timely manner.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time, they had a remit over this designated centre and two other centres. They were supported in their role by a staff team that was comprised of a social care leader and social care workers and ensured they had regular contact with all staff members. They were very knowledgeable of the requirements of their role and responsibilities.

Judgment: Compliant

Regulation 15: Staffing

The provider had not ensured that the number of staff was appropriate to the assessed needs of residents. For example, where residents were assessed as requiring specific staff support, this was not consistently provided to them in accordance with their most up-to-date assessment of need. As a result, the whole-time equivalence (WTE) required was 5.55 WTE, yet the centre only had 3.5 WTE. There also existed a 0.5 WTE vacancy, and one staff member was on long-term sick leave.

The provider had supplemented this deficit with unfunded staffing support of three hours a day for three days a week as an interim arrangement. However, due to the

restraint of covering gaps in cover due to the vacancy and sick leave, it was not always possible to fill the three-hour shifts with relief staff. The provider was required to return a completed urgent compliance plan issued by the inspector within three days of receipt. The provider submitted this plan outlining their strategy to expedite increased staffing levels in the centre. The compliance plan was found to be satisfactory in meeting the needs of residents and the requirements of this regulation.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge and social care leader ensured staff were supported to attend mandatory training on-line or face to-face when safe to do so. There was a training schedule for 2022, and any gaps in training identified from the previous inspection had been scheduled and completed.

Staff were in receipt of regular formal supervision to support them to carry out their roles and responsibilities to the best of their abilities. It was noted that the frequency of supervision was not in line with the provider's policy and instead aligned with a local operating policy. The inspector was satisfied that, in this instance, staff were appropriately supervised in their working practices and abilities to raise any concerns through the full-time presence of the social care leader.

Staff meetings were occurring regularly, and these were well attended. The agenda items were found to be varied and resident-focused. For example, set agenda items included complaints, changing needs, policy review, COVID-19 and safeguarding. Learning following incidents, accidents and near misses were also discussed at these meetings.

Judgment: Compliant

Regulation 21: Records

All records and documentation reviewed on this inspection were found to be clear, accurate, safely secured and easy to retrieve.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured there was up-to-date insurance cover for the centre and had provided a copy of the up-to-date insurance document as part of the registration renewal application for the centre.

Judgment: Compliant

Regulation 23: Governance and management

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 to who they were accountable to.

A schedule of audits and reviews were completed in the centre to monitor and oversee the centre's adherence to service policies, procedures and the regulations. In line with regulatory requirements, comprehensive six-monthly unannounced visits and an annual review of service provision was completed. An action plan was identified following these reviews, which ensured continuous quality improvement in the designated centre. It was an action in the report completed following the most recent unannounced six-monthly visit to the centre that the views of family members were sought for the next annual review.

Whilst the provider had failed to appropriately resource the centre in terms of its staffing levels; the inspector found evidence of prolonged engagement with the funder for this increase in funding which was due for formal assessment; therefore, this deficit was captured under regulation 15: Staffing.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was found to meet the regulatory requirements of Regulation 3 and to accurately describe the services provided in the centre and the governance arrangements.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector found that there were effective information governance arrangements in place to ensure that the designated centre complied with notification

requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure in the centre was reviewed. The centre had a complaints protocol, which was on display in the kitchen with the complaints officer's contact details. As outlined above, residents reported that they would feel comfortable making a complaint if an issue arose. Improvements identified from the previous inspection relating to responding to complaints in line with the providers' policy had been fully addressed.

Judgment: Compliant

Quality and safety

Overall, the inspector found that although the provider was not consistently providing staffing in line with residents' assessed needs, which had the potential to negatively impact the safety and wellbeing of residents, staffing aside, residents who met with the inspector indicated a high level of satisfaction with the service. As indicated under the quality and safety requirements, improvements to the fire containment measures were required to ensure the most optimum standard of fire safety precautions within the centre.

The inspector found that residents were consulted about the care and support they were provided within the designated centre. It was clear from observing residents coming and going to the centre independently that the ability to freely access public transport, visit shops and cafes and do other activities were of importance and, therefore, was supported and encouraged by staff. Residents who met with the inspector said that they were happy with the service they received, and the staff were found to have a good understanding of residents' needs. The residents who lived here had many interests, hobbies and work commitments and were encouraged to lead independent lives to the best of their abilities. On a regular basis, residents met with their keyworkers for a consultation meeting to discuss the progress of their goals, including other matters such as keeping safe during COVID-19, trying out new activities, goal planning and returning to normal activities but to mention a few.

The two houses were observed to be clean, bright and decorated in a homely manner during the walkaround. Each resident had their own bedroom. One bedroom was accessible to wheelchair users and was fitted with equipment to aid transfers as

needed. Bedrooms were decorated in line with residents' tastes and interests. Photographs of the residents and people who were important to them were displayed throughout the house. When walking through the centre, the inspector observed recent premises upgrades were evident with new carpets and painting of rooms underway. The inspector was informed that further works were approved, including flooring to be replaced in a bathroom.

The provider had undertaken an assessment of the fire safety improvement works required in the centre through an external fire safety consultant. A thorough fire risk assessment and an accompanying action plan for the breakdown of works had been prepared for the centre based on this evaluation. The improvement plan included the provision of additional fire containment measures, including fire doors and self-closures. On the walkabout of the two houses, the inspector observed emergency lighting was located in key areas, fire servicing checks were up-to-date, and fire evacuation drills were carried out with good frequency and evaluated different evacuation scenarios. Staff had also received up-to-date fire safety training with refresher training also provided.

The inspector reviewed a sample of the residents' comprehensive assessments and personal plans and found that they provided clear guidance to staff members on the supports to be provided to residents. Appropriate healthcare was provided to residents in line with their assessed needs. Residents received annual health checks with their General Practitioner (GP) and additional allied health professional assessments and reviews as required and relevant to their age profile. There was evidence that residents were supported to change practitioners and medical centres in line with their own preferences. Other allied health professionals were also involved in residents' supports. For example, following recent concerns regarding a mental health decline, there had been an increased input from psychiatry and psychology services.

In line with changing needs, the inspector found there was an increased requirement in the centre for psychology services, behavioural support plans and emotional support. The inspector reviewed a number of behavioural incident logs and found that incidents were appropriately managed and reviewed as part of continuous quality improvement to enable effective learning and reduce recurrence. There were also appropriate risk assessments in place for behaviours that challenge. In discussions with the person in charge and staff, it was clear that additional staff was required in this area in order to provide the supports required by residents. No identified restrictive practices were in place in the centre at the time of inspection. Residents were supported to engage in positive risk-taking and be as independent as possible in their daily lives.

There was evidence of the provider's implementation of both national and local safeguarding vulnerable adults policies and procedures. Staff had received up-to-date training and refresher training in safeguarding vulnerable adults. Overall, it was noted there were a low number of peer-to-peer incidents that occurred in the centre. Residents said that they liked living with their peers and considered each other as friends and housemates. Residents were also provided with intimate care support plan arrangements where required. These plans outlined the specific

support requirements for residents while also outlining their independence skills, were up-to-date and maintained in their overall personal plans.

There was effective management of risk in the centre, with evidence of staff implementing the provider's risk management policies and procedures. A risk register was maintained and updated as required. The register provided a good overview of all managed risks in the centre. Some risks had been identified as high risk. Where these were identified, they were subject to ongoing close review and monitoring. The inspector also acknowledged the person in charge and staff's person-centred management of some personal risks for residents, demonstrating a practical and person-centred approach to managing risks for residents that promoted their independence, such as staying at home alone.

Regulation 13: General welfare and development

The inspector found that residents were supported to have active personal and social lives in accordance with their interests. Residents were central to decisions about their day-to-day care and long term personal goals, and staff supported residents to engage in activities and hobbies of their interest. For example, residents had been consulted with regarding their wishes to return to recently opened days services and work placements. Residents told the inspector they socialised in their local community, visited family members and friends and had visits to their homes.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises were maintained to a good standard throughout. Residents' bedrooms were nicely decorated, and a good standard of cleanliness was observed throughout the centre. The external premises was also well maintained and provided residents with options for sitting or engaging in gardening. Bathrooms and showering facilities were well equipped with assistance equipment and aids where required. Any areas identified for improvement during the walkaround had already been self-identified by the person in charge. On review of the centre's maintenance register the inspector noted improvement with the timeframes outlined for work to be completed as identified on the previous inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

There were clear risk management arrangements in place, and the person in charge had received training in risk management. The inspector found that risk was well managed; the person in charge had ensured that any identified risk was assessed and that necessary control measures were in place. Residents were supported to take personal risks in a manner that supported independence and promoted their safety.

The was a system in place in response to adverse incidents including reporting and recording incidents, a review by the person in charge post incidents, and ensuring that any required follow up interventions were completed.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had taken steps to protect residents from the risk of fire. Fire safety arrangements in each house that made up the centre were reviewed by an appropriately qualified person. The subsequent report identified areas of good practice and areas for modification, including fire containment measures. Improvements were required to the centre as laid out in the fire risk assessment report dated May 2022.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that all residents had an assessment of need and a personal plan in place that was subject to regular review. Assessments of need clearly identified levels of support required. The sample of personal plans reviewed on inspection were found to be detailed, up-to-date, revised regularly and incorporated an allied professional framework and recommendations.

There was a key working system in place, and key workers supported residents to achieve set personal social goals in place, which were agreed upon at residents' personal planning meetings. Goals in place promoted residents to develop independent living skills, hobbies of interest and employment opportunities. Examples of goals that residents were working towards or had completed were: attending concerts again for the first time since COVID-19, taking part in computer classes and going on holidays.

Staff present in the centre demonstrated a good understanding of residents' needs and were seen to provide support in line with the information contained in residents' personal plans.

Judgment: Compliant

Regulation 6: Health care

The centre had good medical and allied health input to ensure that residents' health care needs were assessed and being met. There was evidence of ongoing review by internal and external medical and allied health review as escalated and referred by the person in charge and the staff team.

Judgment: Compliant

Regulation 7: Positive behavioural support

From reviewing a sample of residents' behavioural support management plans and recent consultations with allied health professionals, it was evident that residents' changing needs were being closely monitored and supported. Further consultations with the relevant allied health professionals were being arranged promptly.

There were no identified restrictive practices in operation at the time of inspection and a restraint-free environment was promoted.

Judgment: Compliant

Regulation 8: Protection

There were no active safeguarding plans in the centre at the time of this inspection. Learning from previous incidents had informed residents' support plans. All staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

There was strong evidence that a human rights-based approach to care provision was embedded in the culture of the service. Residents had a say over their lives and participated as fully as possible in decisions regarding the operations of the centre. On a regular basis, residents met with their keyworker for a consultation meeting to

discuss the progress of their goals.

Residents were supported to avail of advocacy services if they chose to and actively participated in decision-making relating to their care and support. For example, one resident expressed their preference for changing medical care facilities and also the photo in their personal plans.
Residents were well-known members of their local community, voted in elections, and lobbied local politicians on matters that were important to them.

It was clear from observing residents coming and going to the centre independently that the ability to freely access public transport, visit shops and cafes, shopping and do other activities was of importance and, therefore, was supported and encouraged by staff.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. John of God Kildare Service DC 11 OSV-0004137

Inspection ID: MON-0028218

Date of inspection: 11/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Additional staffing put in place in the Designated Centre from 25/08/2022. 2. Recruitment request & schedule for recruitment for additional staff completed on 26/08/2022. 3. New rolling roster with additional staffing appropriate to the number and assessed needs of residents put in place from 29/08/2022.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. The actions identified by external fire safety consultant, namely provision of additional fire containment measures; fire doors and self-closures where identified installation will be completed by 31/01/2023.	

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Red	25/08/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/01/2023