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 Company Limited By Guarantee
Address of centre:	Dublin 8
Type of inspection:	Unannounced
Date of inspection:	12 October 2021
Centre ID:	OSV-0003591
Fieldwork ID:	MON-0034495

About the designated centre

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

The designated centre is 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 13 residents. There is one dining area, kitchen, 13 bedrooms, a staff office, a medication room, a family 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 multisensory room located on the campus. Residents are supported 24/7 by nursing staff, healthcare assistants and social care workers. Residents 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:	13

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 12 October 2021	08:53hrs to 16:15hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was a risk inspection to follow up on information received about the quality and safety of care in Arranmore. The inspector had the opportunity to meet with most residents on the day of inspection. The inspector used observations, interactions with residents, conversations with staff and a review of documentation to form judgments on the quality and safety of care in the centre. The inspector wore a face mask, engaged in good hand hygiene practices and maintained physical distancing at all times while in Arranmore. Overall, the inspector was not assured that the provider had the capacity or capability to ensure oversight of a quality and safe service for residents. High levels of non-compliance were identified and immediate and urgent actions were issued on the day of inspection.

The inspector met with many of the residents on the day of inspection. The majority of residents were in bed when the inspector arrived in the morning. Some residents left to go to day service during the course of the inspection however many of the residents were observed to spend much of the day in their bedrooms. Residents in this centre had a variety of complex assessed medical needs and required nursing care. It may have been appropriate therefore for these residents to spend considerable time resting in bed, however the inspector did not observe any activities in the day centre on the day of inspection other than those required to meet intimate care and nutritional needs. Staff reported that some residents have been unable to leave the centre, other than to go to day service, a drive with family or to the local park, since before the start of the COVID-19 pandemic. This was attributed by staff to staffing shortages and difficulty with accessing appropriate transport.

The designated centre was observed to be in a very poor state of repair. Walls throughout the centre had been damaged with paint and plasterboard scraped away. There was evidence of leaks in the ceiling along corridors. The ceiling in the nurses' station had a large crack in it. Staff reported that in very heavy rain, rain can come through this crack and into the building. The heating was on and some rooms were very hot. Staff reported that the heating is always on and that they have no way of controlling it. Staff were relying on fans in nurses stations to circulate air.

The designated centre appeared institutional in decor. Many bedrooms were not painted or decorated in line with individual preferences. Corridors to bedrooms were dark. Furnishings in resident bedrooms appeared institutional. Ceiling fittings were flush with the ceiling, curtains were observed hanging off a rail in one bedroom and several residents' pillows were dirty and unhygienic. Two resident bedrooms had their wardrobes and drawers labelled to identify where their items of clothing should go. There was no evidence that this had been done in line with residents' wishes. This contributed to the institutional presentation of the designated centre.

The bathrooms smelt damp. There were black mildew stains around the grout of a shower as well as staining inside the shower tray. While there were jacuzzi baths

available in the designated centre, these were not accessible to residents. Four bins, used for disposal of intimate care items, were located in one small bathroom. One of these bins was seen to be overflowing.

A fridge, still in it's packaging, was found in the dining room. Staff reported that this had been delivered earlier that week but they did not know where it was to go.

Outside the designated centre was also unhygienic. Discarded PPE was seen in the back garden and on the steps outside the kitchen. An indoor general waste bin was situated at the base of the steps outside the kitchen. This bin contained used face masks which had been disposed of inside the bin without any bin bag. There was evidence of smoking in non-designated smoking areas with many cigarette butts being scattered in the back garden. The back garden required maintenance and was uninviting.

Staff spoken with appeared to know the residents' medical and care needs very well. However staff struggled to provide information about residents' individual preferences, likes and dislikes.

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

Capacity and capability

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 the provider was not demonstrating they had the capacity and capability to provide a safe service to all residents. The findings from this inspection demonstrated the provider had failed to put appropriate and adequate management systems or arrangements in place to assure themselves that a quality and safe service was being delivered. The provider's failure to do this resulted in a service where multiple deficits were found and the inspector was not assured residents were receiving a safe effective service that met their individual or collective needs. There was a systemic failure on the behalf of the provider to provide care and support in a manner that was safe and was meeting the totality of residents' needs. For this reason, a regulatory decision was taken following the inspection to issue a notice of proposed decision to cancel the registration of the designated centre under Section 51 of the Health Act (2007) as amended. This decision was made under the grounds as set out in Section 51 (2) (b) of the Health Act (2007) as amended which states that the Chief Inspector is of the opinion that the registered provider, St John of God Community Services Ltd., is not a fit person

to be the registered provider of the designated centre. This report will set out the findings and areas of significant non-compliance which led to this decision.

This inspection was unannounced and occurred on receipt of information of concern. The purpose of the inspection was to focus on areas relating to food and nutrition. Due to the premises issues that were observed by the inspector and the multiple service deficits that were found the scope of the inspection was widened.

It was found during this inspection there continued to be non-compliances in relation to premises and the governance and management of this centre. The provider had been aware of issues in relation to the instituitionalised nature of this designated centre for several years. Non-compliances in governance and management were identified over multiple HIQA inspections. The provider had committed through their most recent compliance plan in 2020 to address these issues. However, on the day of inspection the inspector could not see that any progress had been made in addressing areas of non-compliance, or where progress had been made, there was evidence that it had not been sustained. For example, in an updated compliance plan received in March 2021, the provider set out that agency staff were not in place in the designated centre and that where additional staff were required, they came from a panel of relief staff who are known to residents. However, on the day of inspection, the inspector met agency staff who were unfamiliar with the residents.

The designated centre had been without a person in charge since July 2021. On the day of inspection, a notification was received to state that a new person in charge was now in place in the designated centre. The person in charge reported to a residential co-ordinator who had a wide remit including several designated centres, respite services and other provider services. Staff told the inspector that it can be difficult to contact senior management. They reported that senior management rarely visited the designated centre. Staff reported that they have attempted to raise concerns however these have not been addressed. For example, staff stated they had recently requested new equipment for the kitchen to assist in safe food preparation however this had not been received. Staff showed the inspector a list of requests that they had written in advance of a meeting with the new person in charge. This list included requests for basic household necessities such as delph and for training in various required areas.

The whole time equivalent staffing ratio for the centre was not clear. The service manager reported that the whole time equivalent had recently been increased however this was not reflected in the roster. Staff reported to the inspector that there was insufficient staffing to meet residents' needs. Staff reported that, at times, they have had to reschedule residents' medical appointments as there were insufficient staff to accompany residents to appointments. Staff reported that it can be difficult to contact service managers. They reported that when staff is on sick leave, the senior staff arrange cover themselves. On the day of inspection there was an agency staff on duty. Senior staff reported that agency arrangements had not been communicated to them in advance of the agency staff arriving on shift that day.

There were gaps evident in terms of staff training. There was no up-to-date training matrix available in the centre on the day of inspection. A soft copy provided to the inspector was found to be out-of-date, in spite of the provider's compliance plan in March 2021 stating that all training was scheduled when due for renewal. Staff were found to be out-of-date in key training areas such as fire safety, managing behaviour that is challenging, dysphagia and manual handling. Staff reported that they had not received any recent formal supervision. New staff, who had started in recent months, reported that they had not received any formal induction or supervision. This meant that staff may not have been providing care to residents in line with current evidence-based best practice.

The annual review was not maintained in the designated centre and staff were not aware of its' content. This demonstrated that the annual review was not considered a working document and was not being used to drive quality improvement. A soft copy of the annual review was made available to the inspector by a manager. This review was found to not be comprehensive and was not reflective of the presenting issues. For example, in spite of known difficulties with governance and management, there was no improvement plan identified for this area. The updated compliance plan received in March 2021 also stated that the annual review was completed and included feedback from family and residents. However, on reading the annual review the feedback of residents was not evident. The annual review further stated that the designated centre was homely, accessible and promoted the privacy, dignity and welfare of each resident. Evidence was found on inspection that this was not the case.

The provider had prepared written policies as prescribed by Schedule 5 of the regulations. However, staff when spoken with were unaware of these policies. There was evidence that the content of these policies was not applied to the care and support of the residents. For example, the policy relating to the monitoring and documentation of nutritional intake stated that staff would support residents to agree a menu. While a menu had been compiled for the week, there was no evidence that this was compiled in consultation with residents. A lack of oversight of the meal preparation and cooking also meant that meals were not being cooked according to the menu. For example, the dinner on the day of inspection was supposed to have been cooked the previous day.

The provider had also been aware of the inappropriate placement of one resident in this centre since 2017 and had committed through their compliance plan in 2020 to sourcing or creating more suitable accommodation for this resident. The annual review in 2020 set out a time frame of three to six months to identify new accommodation. However the compliance plan submitted in 2020 had extended this time frame to March 2022. This extended time frame would mean that the resident will have been living in unsuitable accommodation for five years. It was evident to the inspector on the day of inspection that the current designated centre was not suitable to meet the residents' needs and was having a particular impact on their right to dignity and privacy. This will be discussed further in the quality and safety section of the report.

Regulation 14: Persons in charge

The designated centre had been without a person in charge for several months. While a person in charge had recently been appointed and notified to the Chief Inspector accordingly, there had been no person in charge in place from July to October 2021. It was not clear to the inspector that there were sufficient managerial supports in place to support the person in charge to fulfill their regulatory responsibilities.

Judgment: Not compliant

Regulation 15: Staffing

There appeared to be insufficient staffing on the day of inspection to meet the needs of residents. Staff reported that they were, at times, unable to attend medical appointments with residents due to insufficient staffing levels. Staff also reported a negative impact on residents' quality of life, explaining that due to residents' complex needs and low staffing levels, it was often difficult to arrange trips outside of the designated centre unless it was a walk to the local park.

Agency staff were observed working on the day of inspection. Senior staff were unaware to expect these staff. The use of agency staff did not support continuity of care for residents.

The whole time equivalent staffing designations had reportedly been increased however the roster was not reflective of this. Senior staff reported arranging to cover sick leave and annual leave amongst themselves as it was difficult to contact senior management who had oversight of the roster. Residents' feeding, eating, drinking and swallowing guidelines set out that all residents require assistance and five residents required one to one staff support at mealtimes. On the day of inspection, there were seven staff on duty. Three of these staff were allocated to support two residents and one staff was allocated to the kitchen. This left four staff to meet the needs of the other eleven residents.

The skill mix of staff was inadequate to meet the needs of residents given their complex and varied assessed needs. For example, there was no chef in place in the centre in spite of residents having assessed complex dietary needs. Care staff were preparing, cooking and storing all meals. Care staff were not skilled or trained in this area. This presented a risk to the residents due to multiple steps involved as well as managing the level of complexity involved with adequately preparing, cooking and storing three meals per day for 13 residents with varying dietary requirements.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training needs were not appropriately managed or overseen. The training matrix, when reviewed identified that several staff were out of date in key training areas including:

- fire safety: 18 staff were due this
- managing behaviour that is challenging: 18 staff were due this
- dysphagia: 13 staff were due this
- manual handling: 10 staff were due this

Staff reported that they had not received any formal supervision in recent months. Additionally, new staff reported that they had not completed any formal induction or received additional support. This meant that staff may not have been providing care in line with the most current evidence-based practice.

Judgment: Not compliant

Regulation 23: Governance and management

The provider failed to discharge their responsibilities to ensure the service was safe, appropriate and effectively meeting the needs of the residents. The provider had not implemented adequate assurance mechanisms to oversee the centre and was not operating a service that was of a good standard. Known areas of concern relating to the premises, staffing and governance and management, as highlighted in previous inspection reports, had not been addressed as outlined in their compliance plan response. The failure to act on areas where concerns had been raised meant that residents were in a receipt of a service, and living in an environment, that was suboptimal.

The provider had failed to take timely action to address issues in the centre which had been identified to them through HIQA inspections. The provider had failed to self-identify issues as evident on a review of their audits. The provider's annual review was not comprehensive in nature and was not an accurate reflection of the quality and safety of care and support in the designated centre. The provider had been aware since 2017 that the designated centre was unsuitable to meet the needs of one resident and had not progressed actions to address this.

Staff reported that senior management were rarely in the designated centre and that it could be difficult to contact senior management when their support is required. There was a lack of clarity regarding the roles and responsibilities in the designated centre with staff reporting that they took on additional roles such as

arranging staffing when there were gaps in the roster due to sick leave. Staff were also unclear as to the roles and responsibilities for reporting safeguarding concerns. For example, staff reported they would try to contact a manager through email if they had a concern but they were not confident that this would be responded to. Staff reported that they had raised concerns regarding service deficits and that these were not addressed.

The management systems did not ensure that the service was safe, appropriate to residents' needs and consistently and effectively monitored.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were available in the designated centre. However, staff spoken with were unaware of these policies and there was evidence practices in the designated centre were not in line with the information set out in the policies. For example, menu planning was not completed in consultation with residents.

Judgment: Not compliant

Quality and safety

This section of the report details the quality of service and how safe it was for the residents who lived in the designated centre. The inspector was not assured that residents were receiving a quality service or that the service was managed in a way that identified and mitigated risk in a timely manner. Resulting from this, the inspector had significant concerns regarding the safety of residents living in this centre. Fire management procedures, infection prevention and control and risk management in general were all found to be inadequate. Consequently an immediate action was issued on the day of inspection in relation to fire precautions and two urgent actions were issued in relation to fire precautions and protection against infection. The inspection findings demonstrated that residents' needs and preferences were not at the core of the care provided nor did it drive quality improvement in the centre.

The arrangements for the prevention of fire were found to be inadequate and as a result put residents, staff and visitors to the centre at potential risk. The inspector observed that oxygen tanks were stored in one part of the back garden. These tanks, while stored securely, were located beside combustible materials including waste bins and a shed in which the centre's PPE was contained. The tanks, shed and bins were all located within close proximity of the building and of residents'

bedrooms. Wooden pallets were also observed leaning against the wall of the premises in this area. The provider had not completed a risk assessment as to the storage of oxygen tanks and other combustible materials. An immediate action was issued. The provider sought assurances from their supplier that the oxygen tanks were stored securely however further action was required on risk assessing the storage of combustible materials near these tanks and in close proximity to the centre.

The arrangements for safe evacuation from the centre should there be a fire were also found to be poor and inadequate and as a result an urgent action was issued in relation to the fire evacuation procedures. A review of the centre's site specific emergency plan found that it was out of date and that the floor plans were not an accurate reflection of the designated centre's footprint. A review of fire drills found that these were incomplete and had omitted key details such as the length of time it took to evacuate residents. Staff spoken with were unclear as to the procedures to be followed in the event of a fire. Staff were unsure, for example, which compartment of the designated centre should be evacuated first if a fire were to occur in the kitchen which was located in the centre of the premises. Personal evacuation plans were in place for residents however these had not been considered when determining the night-time staffing allocation and the findings of fire drills. For example, it was documented that at least five residents required two to one support to transfer to their wheelchair in order to be evacuated. Four residents required supervision once evacuated. However, there were only three staff rostered on night duty. Residents would have to be evacuated in their wheelchairs or on ski sheets as bedroom doors were too narrow to allow for residents to be evacuated in their beds.

The risk of fire was further compounded by evidence of smoking in the back garden which was not a designated smoking area. Approximately 35 cigarette butts were scattered on the ground near a drain pipe on the back wall. This was pointed out to senior management on the day of inspection. Management stated that they had addressed this with staff within the last week and had cleaned the butts. There was evidence therefore that smoking continued to occur in spite of direction from management. This was further evidence that the oversight arrangements for the centre were insufficient and presented an additional fire risk to residents.

Deficits in infection prevention and control were found which demonstrated a lack of oversight and monitoring of local preventative arrangements and also highlighted a lack of learning from previous events. An urgent action was issued in relation to protection against infection. The annual review detailed that in early 2020, the designated centre had experienced an outbreak of COVID-19, during which 16 staff and seven residents contracted the virus. One resident died as a direct result of COVID-19. There appeared to have been no learning taken from this outbreak and no enhanced measures to mitigate against the risk of residents contracting a healthcare associated infection. The centre did not have an up-to-date COVID-19 contingency plan. Staff were unaware of who the lead person for infection prevention control was. The inspector observed several poor indicators of infection prevention control measures. These included peeling protective covers on resident pillows with discoloured pillows underneath. Residents' intimate care needs were often provided for in their beds however there was no checklist to ensure that

residents' bed linen was washed regularly. A bin in the bathroom which was used to dispose of intimate care waste was observed to be overflowing. A clinical waste bin was located in the corridor and replacement clinical waste bags were stored on top of a radiator. The utility was worn and dirty. Bags for soiled linen and gloves were stored on top of the radiator which presented a further risk to infection prevention and control. There were two pillows lodged behind the washing machine and dryer. These pillows had spots of black mildew on them. Mould, mildew and stains were observed in resident bathrooms. All of these factors contributed to an increased risk of residents acquiring a healthcare associated infection.

There was a risk register stored in the designated centre however this was out-of-date. The centre's risk management policy was also out of date as were all risk reports reviewed. This meant that staff were not aware of the risks presenting to residents and the measures that should be taken to mitigate against them. Senior management showed the inspector a risk register which was kept online. This was in date however it did not account for risks identified by the inspector including in the areas of fire and infection prevention and control. This demonstrated that the provider's audits were insufficient in identifying risks. Staff spoken with were unaware of how to access the online risk register.

The premises of the designated centre was in a very poor state of repair. Walls were damaged throughout. It appeared that many resident bedrooms had not been painted in a long time. Resident bedrooms were sparsely decorated and appeared institutional in appearance. Ceiling lights were fitted flush with the ceiling, curtains in one bedroom were observed hanging off the curtain rail and another bedroom was missing a roller blind. Wardrobes and drawers in two resident bedrooms were labelled to show where their belongings should go. This was not done so in a manner to support residents with independent dressing, they were labelled by a staff member to make it more efficient for their needs not the residents'. There was no evidence that this was done in consultation with residents or as per their preferences. This contributed to the institutional feel. The house was not homely or comfortable. A staff desk was located in the dining room and resident files were stored on an open trolley beside the desk. This meant that residents' personal information was available to anyone in the dining area. Bathrooms were cold, smelt damp and were inaccessible to residents. Jacuzzi baths were in situ but residents could not access these due to their physical needs. The garden, as previously described, was also unhygienic with discarded PPE and cigarette butts.

There appeared to be insufficient storage in the designated centre to safely store clinical materials such as waste bags and bins as well as staff belongings. Staff were using a small store room which also contained electrical panels and pipes to store their belongings. The room was crowded and staff belongings blocked access to cupboards housing electrical panels and pipes. This had the potential to obstruct access to these panels in the event of an emergency.

There was insufficient oversight of the meal planning, preparation and storage of food in the designated centre. Staff reported that food previously had come from a centralised kitchen within the provider's campus. Staff informed the inspector that this kitchen closed approximately two years ago and, since then, care staff have

been required to cook and prepare all meals for residents. Staff reported to the inspector that they have not had up-to-date training in food safety. Residents in the designated centre presented with a range of complex assessed needs in food and nutrition. Some residents were on specialised diets and staff were required to cook meals which accommodated varying dietary needs including high calorie, low calorie, diabetes and phenylketonuria. Additionally, several residents had been assessed by a speech and language therapist as requiring modifications to their diet and support with meal times. Resident feeding, eating, drinking and swallowing guidelines set out that five residents required one to one support from staff at mealtimes. There did not appear to be sufficient staff on the day of inspection to meet this requirement.

The inspector reviewed the menu planning for the past few months in the designated centre. There was evidence that menus were not in line with provider's policy on food and nutrition. For example, the policy stated that residents should be offered fish twice weekly with one portion of oily fish. The menus detailed that often fish was not offered at all, or occasionally a breaded fish fillet was offered. Menu planning was inconsistent. Staff reported that there was a lack of oversight of the kitchen. On the day in question the staff were cooking a different meal to what was on the menu. It was not clear, that based on the menus reviewed, that residents' feeding, eating, drinking and swallowing guidelines were being implemented. For example, a fry was on the menu for Saturday mornings however this was not in line with several residents' guidelines. Additionally, the inspector raised concerns regarding the nutritional value of the food available to residents. There was a high reliance on chips with several bags of frozen chips, potato waffles and potato slices in the freezer. Staff informed the inspector that when burgers are on the menu, that these are blended with gravy. The inspector questioned the nutritional value of this food and, in particular, the high salt content. The management could not provide evidence that these meals had been approved by a dietitian. Frozen vegetables were seen in the freezer however there was little evidence of fresh fruit and vegetables.

There was evidence of poor planning in relation to food storage. A large tub of chicken breasts (five kilograms in weight) was stored in the freezer. Staff were unclear as to how they would defrost and cook all of this chicken. There was the potential for this to be a risk to residents' health and wellbeing if the food were not defrosted, cooked and stored safely.

The centre was home to a resident who, since 2017, had been identified by the provider as being inappropriately placed in the designated centre. The inspector saw that this resident's dignity and privacy was not always respected in particular in relation to their intimate care needs and their personal and living space. This resident's bedroom was noted to have a bad smell, there were stains on the walls and padded mats were attached to the walls to prevent injury. It was clear that this was not a suitable environment for this resident and was not one wherein they could exercise choice and control over their daily life.

Finally, staff reported that there were limited opportunities for residents to leave the centre other than to go to day service or the local park. The inspector did not observe any activities other than those required to meet intimate care or nutritional

needs on the day of inspection. There was no day activation programme on display for residents who did not attend day service. The institutional nature of the centre along with the poor governance and management arrangements were felt to have significant negative impact on the general welfare and development of the residents.

Regulation 13: General welfare and development

There did not appear to be any opportunities for residents to engage in occupation or recreation other than attending day service or going for a walk to the local park. Not all residents attended day service. Many residents were observed to spend the day in their bedrooms. The inspector did not observe any activities taking place with residents on the day of inspection other than those required to meet nutrition and intimate care. Care provided was task-orientated.

Judgment: Not compliant

Regulation 17: Premises

The premises was in a very poor state of repair. Significant improvements were required to the construction and decoration of the premises as a whole. Key issues identified on inspection included:

- ceiling damaged with evidence of leaks
- walls damaged with plasterboard chipped away
- rooms not decorated in line with resident preferences
- institutional decor e.g. ceiling lights flush with the ceiling, labelled wardrobes and drawers
- bathrooms dirty and inaccessible to residents
- outdoor facilities dirty and unwelcoming

Judgment: Not compliant

Regulation 18: Food and nutrition

While staff were aware and knowledgeable regarding residents' nutritional and dietary requirements, there was poor oversight of the meal planning, preparation and cooking in general in the designated centre. Staff reported that they had not received up-to-date training in how to prepare residents' meals. There was evidence of large volumes of food being purchased and frozen in bulk. The nutritional value of food being provided was also questionable. It was unclear how residents were

consulted with regarding meal planning or how they were supported to make choices regarding their food. Five residents' feeding, eating, drinking and swallowing plans stated that they require one to one support with meals. However, with the staffing levels observed on the day of inspection, it was unclear how this could be provided in a person centred manner.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector found the providers' arrangements were wholly inadequate in identifying, mitigating and controlling areas of risk. The provider failed to take into consideration the complex needs and associated vulnerabilities which residents were susceptible to.

The provider put residents, staff and visitors at staff at risk due to the failings and significant deficits found in:

- fire safety management
- infection prevention control including the the upkeep and maintenance of the premises
- food safety
- availability of resources to adequately meet residents feeding, eating and drinking needs

In addition the centre's risk register, risk management policy and individual risk assessments were out of date. A soft copy of a more up-to-date risk register was maintained. However, this did not account for the risks identified by the inspector on the day of inspection. Furthermore, this online risk register was inaccessible to staff working frontline.

Judgment: Not compliant

Regulation 27: Protection against infection

An urgent action was issued on the day of inspection in relation to protection against infection. In spite of experiencing an outbreak in the centre last year, during which a resident died, the designated centre had no up-to-date COVID-19 contingency plan.

Staff spoken with were unaware of who the lead infection prevention control contact was. There was evidence of poor infection prevention control practices with

discarded PPE being observed in the back garden and on the steps outside the kitchen.

It was not evidenced that residents' laundry was being cleaned regularly in spite of many residents' intimate care needs being provided for in their beds. The utility room was in a poor state of repair. Two pillows which were covered in mould and mildew were noted to be on the floor behind the washing machine.

There were inappropriate practices in relation to storage of clinical waste, with clinical waste bins being stored in corridors and clinical waste bags stored on radiators.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider's fire safety management arrangements were found to be ineffective. There was evidence that the provider had failed to take adequate precautions against the risk of fire and had insufficient procedures in place in order to evacuate all persons to a safe location in the event of fire.

An immediate action was issued on the day of inspection in relation to the storage of oxygen tanks in close proximity to combustible materials and to the premises. The storage of these tanks beside combustible materials had not been risk assessed.

An urgent action was also issued in relation to the fire evacuation procedures. The inspector was not assured that all residents could be safely evacuated in the event of fire. Not all staff had up-to-date fire safety training. Fire drills had not been recorded accurately and did not reflect key pieces of information such as the length of time to evacuate residents. Staff were unclear of the procedures to be followed in the event of fire.

The designated centre's site specific emergency plan was out fo date. The floor plans on this document were not an accurate reflection of the footprint of the centre.

There was evidence of smoking in non-designated smoking areas which further increased the risk of fire occurring.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider failed to demonstrate the residents were at the centre of the service that was being operated.

Although it appeared that the nursing and care staff were doing their best to meet the residents' needs, the care provided was task orientated and did not afford residents the opportunity to live their best life.

The premises itself was institutional in nature. For example:

- there were labels on wardrobes stating where clothes should go
- signs on wardrobes instructed staff to put clothes away correctly
- padded mats were in place on the walls in one bedroom
- there was little evidence of personalisation in the decor of bedrooms
- bed linen was mismatched
- blinds and curtains were broken or missing
- ceiling lights were flush with the ceiling throughout the centre
- bathrooms were inaccessible and unhygienic

Residents were not engaged with regarding their preferences. There was no activity schedule up for those residents who did not attend day service. The food being offered was not consistent with the menu plan. Although the centre's annual review stated that it consulted with residents, their views and opinions were not reflected in the review.

In addition a resident continued to reside in this designated centre in spite of the provider having identified several years ago that the centre was not suitable to meet this resident's assessed needs. The inspector saw that this resident's dignity and privacy was not always respected in particular in relation to their intimate care needs and their personal and living space. It was clear that this was not a suitable environment for this resident and was not one wherein they could exercise choice and control over their daily lives.

Judgment: Not 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	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Arranmore OSV-0003591

Inspection ID: MON-0034495

Date of inspection: 12/10/2021

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • The registered provider (has appointed a full time supernumerary Person in Charge (PIC) who is the Residential Coordinator to the Centre with effect from 8 November 2021. • The PIC is solely responsible for this Centre • The person has the required skills, knowledge, experience and qualifications necessary for the role. • The PIC has been fully inducted in the Centre by the Programme Manager (PM).	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC has ensured the following: • There is a planned and actual roster available in the Centre which confirms the staffing levels and grade for each shift. • These rosters are communicated to all staff of the Centre via email. Hard copies are also available in the staff office. • This roster is monitored; any issues that arise are addressed by the PIC. • A review of this roster has been undertaken by the PM on the 2 November 2021 to address the staffing shortfalls in the Centre and has amended same to include additional staffing (49hours weekly for day duty), (2 HCA's on night Duty), (1 chef), (1 activity instructor to commence duty on 29 November 2021) in the Centre. The Registered Provider is now assured the roster has an appropriate skill mix of health and social care staff to safely support and meet the assessed needs of the residents. • This has resulted in the WTE of the Centre being increased from 34.5 WTE to 38.5 WTE with additional staffing support hours from the catering department. • A recruitment campaign has been instigated to recruit a Clinical Nurse Manager 1 and to fill other existing vacancies in the Centre on 10 November 2021. A specialist recruitment agency is being used. • To cover all staff absences, a panel of four relief staff is available (3 social care	

workers, 1 health care worker). The relief panel is currently being expanded through an open recruitment competition for social care workers, health care assistants and nursing grades of staff that will be available for work in the Centre; this will provide continuity of care and support for our residents.
• All new staff are fully inducted by the PIC and undergo a 12 month probationary period.
• In the interim, three specific agency staff (social care worker grades) have been engaged in the Centre and are fully inducted by the PIC.
• Approved agency staff are only engaged to provide cover when all other avenues have been exhausted.
• The chef and the General Services Coordinator have completed food safety training with the staff team.
• A professional chef has commenced working in the Centre from 01 November 2021. This person, in conjunction with residents and keyworkers, are involved in meal planning and choice of preferred meals. Part of the mealtime planning takes account of residents' specific modified diets and the Organization's food, nutrition and hydration policy.
• Residents are supported with exercising their choice and preference with menu planning; this is evident in the residents meetings.
• An Activity Instructor has been identified to lead community inclusion and meaningful activities for all residents and will commence in the Centre on 29 November 2021.
• 8 Residents are availing of formal Day Services external to the Centre.
• 5 residents are currently being assessed for a formal day service by the day service manager with a view to accessing a formal day programme to suit resident's individual needs. It is envisioned that residents will commence in their day service in the New Year. In the interim, these residents are receiving a wraparound service whereby staffs from the Centre are supporting their meaningful day activities.
• To support all residents' meaningful day, their schedules are currently being reviewed and updated to reflect their preferred activities and will and preference by 26 November 2021. This is overseen by the PIC on a weekly basis.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The PIC has ensured:
• A review of the training records for all staff has been completed by 26 October 2021.
• All staff working in the Centre will have completed mandatory training (infection Prevention and control, safeguarding vulnerable people, dysphagia, fire safety and fire extinguisher, manual handling) by 26 November 2021.
• All staff have been scheduled to receive person-centered workshops commencing 11 November 2021 and ongoing, as required by two identified designated Programme Managers.
• The Senior Speech and Language Therapists are delivering Triple C Communication training for staff on the 15 November and will be completed by 26 November 2021 for all staff.
• In addition, other identified training has been scheduled for all staff by 26 November 2021 such:
· Positive behavior support training.

- practical sessions on infection prevention and hand hygiene
- person-centered planning Approach
- Human rights.
- medicines management,
- Epilepsy
- HIQA regulation & standards
- Food Safety and food preparation.

.

• A database of all training records for this centre is maintained by the HR department and updated weekly by the PIC.
• A schedule has been developed and put in place to complete supervision with all staff by 26 November 2021.
• Formal staff supervision commenced on 27 October 2021.
• A 2022 staff supervision schedule is being developed by the PIC, by 26 November 2021.
• All new staff including relief and agency will be provided with a robust induction by the PIC and/or the most senior staff member on duty. An induction booklet is available to support this process.
• Weekday information sessions now take place to enhance practice development for all staff on duty. These sessions commenced on 9 November 2021 by the PIC.
• Designated 'Shift Leaders' are present on each shift and roles and responsibilities of same have been outlined to all staff by the PIC and the PM.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A series of meetings have taken place involving regional and executive management to discuss and address the findings of the recent HIQA inspection. To support and continuously drive the transformation plan of the centre that is required in order to meet regulatory standards, the following actions have been/ are being taken:
• A review of the governance and management structure for the Centre has been undertaken.
• Following on from this review the following actions have been undertaken:

o The current Clinical Nurse Manager 2(CNM2) is being replaced by a full-time permanent, experienced CNM2 with effect from 15 November 2021.
o A recruitment campaign has been instigated to recruit a CNM 1.
o The registered provider (has appointed a full time supernumerary Person in Charge (PIC), who is the Residential Coordinator, to the Centre with effect from 8 November 2021. The PIC is solely responsible for this Centre. The person has the required skills, knowledge, experience and qualifications necessary for the role.

• All staff have been issued with the management structure of the centre on 1 November 2021 by the PM via email and the contact details for the management team are located in the office.
• The Statement of Purpose has been reviewed and updated on 11 November 2021, and is available in the centre.

• There is a procedure in place for arranging cover for all staff absences; the staff team has been reminded of same during daily handover.
• A team huddle now takes place daily in the centre; this is facilitated by the PIC or senior staff member on duty since 8 November 2021.
• The Programme Manager links in daily with the managers and shift leaders in the designated centre to receive an update on resident, staffing levels, incidents, any safeguarding concerns and issues.
• The PM meets with the staff at team meetings with the PIC on a twice weekly basis. The PM is on site minimum twice weekly since 13 October 2021.
• The PIC, CNM2 and PM meet formally monthly to discuss all concerns and issues arising during centre Review Meetings.
• Fortnightly, Monitoring and Compliance update meetings will take place between the PIC, PM and CNM2 with effect from the 15th November 2021. These meetings will take place fortnightly for the first three months of the action plan and monthly for six months to cover medium term actions and every two months thereafter. An agenda for these meetings will be developed to cover the key areas of compliance and focus on agreed corrective actions and evaluation of same. A note of these meetings will be retained by the PIC in the centre.
• The PIC and PM will complete a walk around of the centre on a weekly basis to ensure agreed actions are being implemented and regulations are being adhered to.
• The PPIM/PM escalates relevant concerns arising from the Centre to Interim Regional Director during monthly Programme Manager/Regional Director meetings and/or at bi-monthly at Regional Management team Meetings.
• All staff have been provided with Organisational policies and procedures on 19 October 2021. These will inform practice development as described in regulation 15.
• A full regulation Audit has been undertaken on behalf of the Registered Provider on 20 October 2021. All actions identified to address areas of non-compliance are included in the Centre's Quality Enhancement Plan.
• The Site Specific Emergency Plan has been reviewed and updated in line with the fire safety specialist recommendations on 21 October 2021. This Plan was shared with staff on the 3 November 2021. Two fire safety drills have been completed in the centre post HIQA inspection.
• An Annual Review for 2021 will be completed for this Centre and consultation will take with all key stakeholders by 31 March 2022.
• The Floor Plans are being updated and will be submitted to the authority following receipt from the architect.
• Formal supervision will take place with staff as outlined in regulation 16 above.
• Refer to regulation 16 above regarding staff training.
• The QEP is updated and includes all actions from internal and external audits and inspections.
• A review of safeguarding incidents have taken place by the PM and Designated Officer (DO) on 4 November 2021.
• All safeguarding incidents continue to be reported to the PIC and DO.
• PIC will review safeguarding concerns as part of the monthly agenda with Residential Programme Manager.
• The Programme Manager escalates their concerns at monthly Interim Regional Director Meetings.
• Online safeguarding staff training has commenced and will be completed by 26 November 2021.

• Additional Safeguarding workshops have been scheduled for all staff for the 14 and 16 November 2021.
• Six monthly unannounced visits on behalf of the RP visits will resume onsite in December for this centre.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The RP has ensured:
• All up to date local and Organisational policies (including Schedule 5) were emailed to staff on the 19 October 2021 and are available within the Centre since 12 October 2021.
• All Schedule 5 policies as approved by the SJOG Community Services Board are also available on the staff intranet.
• The implementation of schedule 5 policies and procedures will be regularly monitored by the PIC.
• Schedule 5 policies also inform practice development with staff.
• Policies are a standing item at each staff meeting and formal supervision meeting.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The RP has ensured the following is in place and being actioned:
• To support all residents' meaningful day, their schedules are currently being reviewed and updated to reflect their preferred activities and will and preference by the 26 November 2021
• A will and preference survey in terms of residents' wishes regarding participating in day services was completed on the 25 June 2021.
• All staff are currently attending training on Person-centered approach action workshop as facilitated by the Coordinator of the Callan Institute that commenced since the 5 November 2021 and is ongoing until all staff have received this training.
• 8 Residents are availing of formal Day Services external to the Centre.
• 5 residents are currently being assessed for a formal day service by the day service manager with a view to accessing a formal day programme to suit their individual needs. It is envisioned that they will commence in their day service in the New Year. In the interim, these residents are participating in a wraparound service whereby staff from the Centre are supporting their meaningful day.
• Keyworkers are working directly with residents and their representatives to support them to identify their preferred activities and personal goals. This action will be completed by the 26 November 2021.
• The Senior Speech and Language Therapists are delivering Triple C Communication training for staff on the 15 November and will be completed by 26th November 2021 for all staff.
• An activity instructor has been recruited to develop and drive the meaningful day experience based on the will and preference with the residents. Instructor due to commence on 29 November 2021.

• Each resident will have an accessible activity schedule in place by 31 December 2021.
• An alternative location has been identified for residents to use at evenings and weekends for preferred individual activities; commencing 15 November 2021.
• A professional chef has commenced working in the Centre from 1 November 2021. This person in conjunction with residents and keyworkers are involved in meal planning and choice. Part of the mealtime planning takes account of residents' specific modified diets and the Organisation's food, nutrition and hydration policy.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider has ensured the following:
• A fire safety, environmental and infection control audit were completed on 15 October 2021; findings from these audits are being actioned in the Quality Enhancement Plan (QEP), with most actions completed by the 26 November 2021.
• All practices relating to labelling of residents furnishings has been discontinued from 13 October 2021.
• Painting and re-decorating of the communal areas in the centre will be completed by 26 November 2021.
• The communal areas of the centre will be decorated in a more homely manner.
• Residents were consulted about their preferences for the redecoration of their bedrooms and will be supported to decorate their bedrooms in line with their likes and preferences.
• New flooring will also be installed in the communal areas and resident bedrooms by 26 November 2021.
• Damaged walls have been repaired.
• Two bathrooms will be refurbished by 26 November 2021 to wet rooms to allow the bathrooms to become more accessible to residents.
• In addition, a further two bathrooms will be refurbished by 28 February 2022 into wet rooms.
• A deep clean has been completed of the kitchen by an external company on Monday 1 November 2021.
• A review of cleaning schedules has taken place to ensure a high standard of cleanliness in the Centre and cleaning checklists take into account infection prevention and control; PIC will monitor these schedules and checklists.
• The housekeeping staff and frontline staff for this centre have been involved in this process and are aware of the heightened cleaning procedures.
• A review of the heating system will take place by 26 November 2021 to account for the regulation of the heating system in the centre.
• The shed at the back of the centre has been removed and the combustible materials have been relocated to another area on site.
• Door closers will be fitted by the 16 November 2021 as required.
• A new laundry procedure will be in place by 19 November 2021. The laundry facilities have been reviewed and new machines have been purchased to meet the individual needs of residents.
• New furniture for communal areas has been purchased and will be in place by 26 November.
• Externally, the premise has been power washed on the 8 November 2021.
• Following all environmental actions being completed by 26 November, 2021 a further

environmental audit will take place by 3 December 2021 to ensure that there is no outstanding action required.
• An internal deep clean of the full premises will be completed by 27 November 2021 following the completion of renovation works.
• There is an identified secure location for staff offsite for rest breaks and personal belongings/storage.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The PIC has ensured the following:
• A professional chef has commenced working in the center from 1 November 2021.
• This person has responsibility in consultation with keyworkers and residents for meal planning, choice, preparation and cooking of meals in line with the residents' specific modified diets and the organisation's food, nutrition and hydration policy.
• This person along with the General Services Coordinator supports the PIC to educate and support the staff team with providing positive mealtime experiences for the residents in the centre.
• Residents will be supported with exercising their choice and preference with menu planning; this will be evident in the residents meetings.
• Residents meetings are currently being held weekly. Consultation and training is taking place with the Speech and Language Therapist following which the format of these meetings will be reviewed and redesigned to meet the needs of the residents. This action will be completed by the 3 December 2021 and will be overseen by the PIC and PM.
• The Speech and Language Therapist has completed a review of all residents dysphagia, eating drinking and swallowing assessments and modified diet plans on 4 November 2021. The Speech and Language Therapist is providing refresher dysphagia training for all staff in the centre, this training will be completed by the 26 November 2021.
• A referral for all residents was made to a private dietician on 27 October 2021 by PM for assessment purposes.
• Following a review of the mealtime experience by PIC and PM on 27 October 2021, staff breaks are now being staggered, this will ensure there are adequate and appropriate staffing levels at mealtimes.
• A mealtime experience audit will be carried out by General Services Co-coordinator by 16 November 2021.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The RP has ensured:
• The review of fire safety evacuation procedures and fire safety register has been completed on 19 October 2021 by the PIC.
• An independent fire specialist review took place on 21 October 2021.
• The specialist advised that the centre is a low fire risk building due to its design and layout. The advice given if evacuation is to take place in the event of an emergency, a progressive horizontal compartmentalized evacuation should take place.

• Covid risk assessments were completed by 20 October 2021.
• A review of the risk register commenced by the PIC and Clinical Safety Manager and will be completed by the 12 November 2021.
• Hazard identification and associated risk assessments are being updated in line with the SJOGCS risk management policy by 26 November 2021.
• Any identified issues will be reviewed by the PIC and PM fortnightly at the compliance and monitoring meetings.
• Staff have access to the Risk Management System (RMS).
• The risk register review has commenced and will be completed by 12 November 2021.
• RMS and risk management will be a standing agenda item for all meetings chaired by the PIC with effect from 19 November 2021.
• The Speech and Language Therapist has completed a review of all residents dysphagia and modified diet plans on the 4 November 2021. Associated risk assessments have commenced and will be completed by 26 November 2021.
• Risk assessment workshops will be scheduled for staff, as facilitated by Clinical Safety Manager by 26 November 2021.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The RP has ensured:
• All staff have completed online refresher training in Infection Prevention and Control (IPC) by the 19 October 2021.
• All staff will attend refresher hand hygiene practical sessions by 26 November 2021 as facilitated by the Assistant Director of Nursing/IPC lead.
• A review of the Regional Covid-19 contingency plan was undertaken on the 19 October 2021 by the Regional Management Team.
• Review of Covid contingency Preparedness plan was reviewed and updated by the PM on the 19 October 2021.
• The Covid contingency folder was reviewed and updated on the 18 October 2021 by the PM.
• An IPC audit was completed on 15 October 2021 by ADON/IPC lead. Identified actions are being addressed as per QEP.
• An environmental audit was completed on 15 October 2021 by Regional Operations Manager. Identified actions are being addressed as per QEP.
• IPC accessible documents are being developed and will be in place for residents by the 26 November 2021.
• IPC is a standing agenda item at residents' meetings.
• A deep clean of the kitchen has been completed by an external company on 1 November 2021. A further deep clean is scheduled to take place on completion on renovations.
• A review of cleaning schedules took place and improved cleaning checklists are in place and being monitored to ensure a high standard of cleanliness.
• The Safety Pause was put in place at daily handovers to increase staff awareness in IPC.
• Waste management practices have been reviewed as part of the environmental and IPC audits and additional waste and clinical waste collections have been implemented on

the 15 October 2021.
• Additional laundry equipment has been ordered for this centre.
• A new laundry procedure will be in place by 19 November 2021.
• Staff allocation lists have been amended to ensure that there is a dedicated staff responsible for ensuring high standards of resident's laundry each day.
• A cleaning checklist and cleaning kit is in place for the transport vehicles. This checklist will be monitored daily by the shift leader by 15 November 2021.
• PPE storage and combustible materials have been reallocated to an alternative area.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The RP has ensured:
• An independent fire specialist review took place on 21 October 2021.
• The review of fire safety evacuation procedures and fire safety register was completed on 19 October 2021 by the PIC.
• The risk register review commenced and will be completed by the 12 November by the PIC and the Clinical Safety Manager.
• Hazard identification and associated risk assessments are being updated in line with the SJOGCS risk management policy by 26 November 2021.
• Oxygen use and storage has already been reviewed Irish Gases and Safetech as part of the completion of the PAS79 fire risk assessment. Safetech have confirmed the oxygen storage is now satisfactory and no further action is required.
• All Personal Emergency Evacuation Plans have been reviewed to reflect changes in their evacuation procedure and returned to the PM by 21 October 2021.
• All doors in the Centre will be fitted with magnetic fire door closer's that will be connected to the fire system by 18 November 2021.
• A review of the fire safety register has been completed on 19 October 2021.
• All staff with the exception of one staff has completed online fire safety training.
• Refresher training on fire evacuation procedures by an external fire expert has been completed by 26 November 2021.
• The smoking procedure has been reviewed and updated to reflect the needs of the Centre by the Programme Manager on the 19 October 2021.
• There is a designated smoking area located away from the Centre.
• All staff have been inducted into this procedure during a staff meeting held on 19 October 2021.
• There is also a notice for staff on the notice board directing them to the designated smoking area.
• The shed and combustible materials have been removed from the perimeter of the Centre and the combustible materials have been relocated to another area on site.
• The Site Specific Emergency Plan was reviewed on the 22 October 2021 by the PM.
• Easy Read tools in relation to fire safety and evacuation will be in place by 26 November for all residents.
• Safety Specialists will have drafted and issued a combustible policy for the designated centre by the 26 November 2021.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The RP shall ensure:
• The communal and bedroom areas of the centered are currently being decorated in a more homely manner and will be completed by 26 November 2021. The residents are being supported to personalise and decorate their bedrooms in line with their likes and preferences. This is being be supported by the personal planning process.
• All labels have been removed from the resident's bedrooms on 13 October 2021.
• Two bathrooms will be converted into wet rooms by 26 November 2021, with the further two bathrooms refurbished into wet rooms by 28 February 2022.
• All staff will have completed workshops on person centered planning aligned to the Organisations Person- Centered Approach Policy by the 20 November 2021. All staff have completed Person Centered Approach Action to service delivery workshops by 26 November 2021.
• In relation to the resident that requires a low arousal environment, alternative accommodation has been identified, funding and extensive works are required to bring this location in line with regulation. The timeframe being currently advised is summer 2022.
• This resident's positive behavior support plan is currently being updated to review and support this resident's dignity and privacy and will be completed by the PIC, CNS and Senior Psychologist by 26 November 2021. In addition, staff are receiving training on human rights based approach which will drive the importance of dignified and respectful care of all residents within the designated centre.
• A professional chef has commenced working in the designated centre from 1 November 2021.
• This person has responsibility in consultation with keyworkers and residents for meal planning, choice, preparation and cooking of meals in line with the residents' specific modified diets and the organisation's food, nutrition and hydration policy. This person along with the General Services Coordinator will also support the PIC to educate and support the staff team with providing positive mealtime experiences for the residents in the centre. Residents will be supported with exercising their choice and preference with menu planning; this will be evident in the residents meetings.
• Residents meetings are currently being held weekly. Consultation and training is taking place with the Speech and Language Therapist following which the format of these meetings will be reviewed and redesigned to meet the needs of the residents. This action will be completed by the 3 December 2021 and will be overseen by the PIC and PM.
• The Speech and Language Therapist has completed a review of all residents dysphagia, eating drinking and swallowing assessments and modified diet plans on 4 November 2021. The Speech and Language Therapist is providing refresher dysphagia training for all staff in the centre, this training will be completed by the 26 November 2021. A referral for private dietician was made 27 October 2021.
• An alternative location is identified for residents to use at evenings and weekends for preferred individual activities commencing 15 November 2021.
• Monthly resident meetings facilitated by the PIC to commence in November where residents with keyworkers have an opportunity to discuss their freedom to exercise choice and control his or her daily life.
• Refer to regulation 13 above for all other actions taken.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Red	26/11/2021
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Red	26/11/2021
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Not Compliant	Red	26/11/2021

	accordance with their interests, capacities and developmental needs.			
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Red	26/11/2021
Regulation 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Red	26/11/2021
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	26/11/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	29/11/2021

Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	29/11/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Red	26/11/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	26/11/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Red	26/11/2021
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	Not Compliant	Red	26/11/2021

	externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Red	26/11/2021
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 safely prepared, cooked and served.	Not Compliant	Red	26/11/2021
Regulation 18(2)(b)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Not Compliant	Orange	03/12/2021
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Not Compliant	Orange	03/12/2021
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Not Compliant	Red	26/11/2021

	are consistent with each resident's individual dietary needs and preferences.			
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.	Not Compliant	Red	26/11/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Red	26/11/2021
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Red	26/11/2021

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.	Not Compliant	Red	26/11/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	26/11/2021
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	26/11/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the	Not Compliant	Red	26/11/2021

	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.	Not Compliant	Red	26/11/2021
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Red	26/11/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to	Not Compliant	Red	26/11/2021

	in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Not Compliant	Red	26/11/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Red	26/11/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of	Not Compliant	Red	26/11/2021

	risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	26/11/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	26/11/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	26/11/2021
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention,	Not Compliant	Red	26/11/2021

	emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	26/11/2021
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	Red	26/11/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice	Not Compliant	Red	26/11/2021

	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.	Not Compliant	Red	26/11/2021