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:	Newmarket Residential
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	29 August 2022
Centre ID:	OSV-0005528
Fieldwork ID:	MON-0037802

About the designated centre

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

In this centre the provider aims to provide, in consultation with residents and their families, a safe and welcoming home environment for residents in their own community. The support provided is tailored to specifically meet each person's needs, to provide opportunities to enjoy independence while still connected to family and home and, to participate in social activities, hobbies and community engagement that is suitable, meaningful and age appropriate. Residents receive an integrated type service where both residential and day services are provided from their home. Support is provided by a team of social care staff with management and oversight provided for by the person in charge supported by a social care worker. Each apartment is staffed by day and at night one staff on sleepover duty provides support as needed for both apartments. The premises consists of two separate adjacent, ground floor apartments with accommodation provided in each apartment for two residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Monday 29 August 2022	09:45hrs to 17:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken to monitor the provider's ongoing compliance with the regulations. Based on what the inspector observed, read and discussed there was an evident commitment to providing each resident with a safe, quality service. There was evidence of efforts to continuously improve the quality and safety of the service. However, notwithstanding this, these inspection findings were not satisfactory. There were challenges to ensuring the quality and safety of the service such as the compatibility of resident needs, the complexity of resident needs and the requirement for consistent management, support, staffing levels and arrangements. These impacted on the quality and safety of the service and required robust and consistent governance and management. There was an absence of assurance that this required level of governance was always in place.

The designated centre consisted of two separate adjoining apartments. This inspection was unannounced and on arrival at the first apartment the inspector noted that staff on duty were wearing medical grade face masks as outlined in infection prevention and control guidance. Staff ascertained that the inspector was well prior to the inspector entering the designated centre. One resident was up and about and preparing his own breakfast. The resident welcomed the inspector to their home and asked the inspector if they would like to join them for some refreshments. The inspector thanked the resident but declined so as not to accidentally expose the resident to infection as the inspector would have had to remove their own face mask.

The second resident was completing personal care in their bedroom and came to greet the inspector when this was complete. The inspector noted how staff gently reminded the resident to get and use their mobility aid. The resident who had experienced some poor health looked very well and told the inspector that they felt very well. The resident said they were happy to be back in the centre having transferred to another centre for a brief period of time. Both residents proceeded to have a leisurely breakfast together supported by staff.

The inspector accompanied by a staff member went to the adjoining apartment where one resident used the intercom to ascertain who was at the door before they opened the door. The resident invited the inspector to enter their apartment and gave the inspector a tour of the apartment. The inspector noted how the resident did not enter their peer's bedroom or the shared bathroom that was occupied by their peer. The resident was in good form, shared family photographs with the inspector, and discussed their love of music and their visits to home. The resident told the inspector how much they had enjoyed a trip to a heavy vehicle road-show accompanied by a staff member. The resident discussed the working of the fire detection and alarm system and the evacuation procedure. The resident described how they liked to choose and prepare their own meals but got help from staff with the actual cooking. Their peer was present in the apartment but did not respond to

the greeting offered by the inspector and this was respected.

This was a service where the individuality of residents and their changing needs was recognised. Residents were listened to and supported to express their choices and concerns. For example, the inspector observed a staff member to discuss and agree with one resident their weekly shopping list. The resident clearly articulated their preferred options. The person in charge was available to residents and supported residents to access and use the provider's complaint procedure as they wished. The person in charge recognized challenges to residents effectively communicating their needs and wishes and clinical support had been put in place to support this.

What was evident however from this engagement was that residents were not always happy with their living arrangements. The person in charge had commenced an assessment of the compatibility of two residents to live together. A process of communication supported by staff was in place in the other apartment so that residents developed a better understanding of the others needs and wishes. This was at an early stage but appeared to be going well.

The inspector revisited one apartment in the evening. One resident again declined to engage with the inspector and this refusal appeared to impact negatively on the other resident and the general atmosphere in the apartment. The person in charge who was present was very attuned to this and said that an earlier planned joint activity had not been to the liking of both residents. This was managed by the person in charge and while the joint activity had not taken place as planned the person in charge advised there may have been a lingering impact. The other two residents had enjoyed a trip to a nearby seaside resort with a staff member. On their return to the centre residents confirmed they had enjoyed their trip but they were not as eager to engage with the inspector. The inspector enquired as to whether they were tired but they said they were not.

Staffing levels and challenges to maintaining appropriate staffing levels exacerbated the incompatibility of resident needs as they did not always support individual choices, preferences and routines. This was evidenced on the day of inspection and will be discussed later in this report.

The provider therefore needed to assure itself that it had the arrangements in place to meet each residents needs so that they were consistently happy and well and enjoyed a good quality of life. In addition, and in relation to meeting resident needs, there was evidence that the personal plan was not always adhered to by all staff members. There was evidence of action taken to address this by the person in charge through supervision, monitoring and formal communications to the staff team. However, based on the evidence available to the inspector this was an ongoing matter to be addressed by the provider.

Residents had good opportunity to be engaged in their community and to enjoy new activities; ample provision was made for transport. Residents discussed the planning of a trip away to enjoy a concert. A resident had recently enjoyed the experience of sailing organized by a staff member and plans were in progress for the resident to recommence swimming. The matter arising was that residents did not always want

to do the same things and to do them together.

Residents had ongoing contact with family. Representatives were consulted with and had been invited to provide formal feedback outlining their experience of the service. The inspector requested and reviewed this recent feedback which was good but also mixed. The response rate was good and while overall the feedback was positive reservations about the service were also raised. These reservations would concur with the findings of this HIQA inspection as to the adequacy of staffing levels and inconsistent practice.

In summary, there were positive aspects to this service and a clear desire to provide residents with the best possible service. However, there were matters arising that were impacting on the quality and safety of the service. It was a service that required but did not always have robust, effective and consistent governance.

The next two sections of this 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 residents.

Capacity and capability

The management structure, individual roles, responsibilities and reporting relationships were clear. However, this did not ensure the service was consistently and effectively monitored or, where improvement was needed it was achieved in a timely manner.

For example, the person in charge worked fulltime and demonstrated a deep commitment to ensuring each resident received the best possible service as appropriate to their needs and, as outlined in their personal plan. However, the person in charge had been on unplanned leave. The inspector saw that the service review completed by the provider in early June 2022 had noted in response to that leave that arrangements were needed that ensured consistency in governance and management. Staff spoken with by this inspector told the inspector that this period was very challenging for them and while they had access to management they missed the strength of guidance and support provided by the person in charge. It was recorded in the minutes of a staff meeting that the staff team felt there was insufficient support for the service when the person in charge was absent. This was of concern given that a further planned absence was imminent.

In addition, staff employed as social care workers, a role junior to and designed to support the person in charge in the management and oversight of the service also worked as front-line staff. These staff were to have allocated days for administration and management duties each week. Staff spoken with said that staffing deficits

meant that they did not always have this protected time and they had to assume front-line staffing duties more often than would be preferred. This impacted further on the management of the service a fact that was also captured in the recent internal review. This was also evidenced on the day of this inspection with the social care worker assuming front-line duties due to a staff absence.

In general, a full review of staffing levels, arrangements and staff management was needed. There were vacancies that impacted on the ability to maintain the current agreed staffing levels. For example, a staff member confirmed there was an ongoing vacant weekend shift. These staffing deficits did not take into account the identified need to provide residents with more one-to-one staff support due to increasing evidence of needs that were not compatible. This was identified at the time of the last HIQA inspection and five additional hours had been allocated in response. The person in charge said that this was very beneficial to the resident but not sufficient to address the incompatibility.

A number of staff working in this centre also worked across a number of areas and this did not support consistency of staffing. For example, the staff rota for one apartment indicated sixteen staff were required though a maximum of two staff were on duty each day. The person in charge said one staff had recently been recruited, a recruitment initiative was in process and a business case had been submitted seeking additional staffing resources. The person in charge had two open staff related high risk assessments for the impact on the quality and safety of the service.

The inspector established with the person in charge what arrangements were in place to ensure staff were appropriately supervised as required by the regulations. The person in charge confirmed formal staff supervisions were in place and a specific process of engagement had recently commenced in the form of reflective practice facilitated in part by an external stakeholder. The person in charge who was not based on site also undertook unannounced spot checks. However, based on these inspection findings, the inspector was not assured that these measures were sufficient or effective in ensuring consistency of practice.

These will be discussed again in the next section of this report but an identified risk management control was regular staff meetings. Based on the records seen by the inspector three staff team meetings had taken place to date in 2022. There was good discussion at these meetings. However, there was only a 50% or less attendance at each of these meetings and three staff members had attended none of the three meetings.

Regulation 14: Persons in charge

The person in charge worked full-time and had the experience, skills and qualifications needed for the role. The person in charge was committed to and sought to ensure the provision of a safe, quality service to each resident. The person in charge was very aware of their role and responsibilities and could

evidence to the inspector that they escalated matters arising to the provider and advocated for residents. The person in charge was very aware of the improvement needed in this centre and the requirement for strong consistent governance to ensure and assure the quality and safety of the service provided to residents. The person in charge was actively engaged in the management and oversight of the service, was available to staff and residents and very familiar with the needs and changing needs of each resident.

Judgment: Compliant

Regulation 15: Staffing

A full review of staffing levels, arrangements and staff management was needed. There were vacancies that impacted on the ability to maintain the current agreed staffing levels. For example, the staffing levels on the day of inspection were not as planned. These staffing deficits did not take into account the identified need to provide residents with more one-to-one staff support due to increasing evidence of needs that were not compatible. For example, on the day of inspection it was planned for two residents to go out together for tea but one resident advised the person in charge that they did not want to do this. The person in charge was on site and arranged for a staff member to support each resident to do what they wanted to do. However, one of these staff members should have been on administration duties. Two residents had separately communicated (as recorded on records seen) how they felt lonely and alone at times in their apartments especially at night. One apartment was not staffed at night; a staff member on sleepover duty was based in one apartment. Staff described the challenge of managing a number of staff who worked across different areas. This inconsistency presented challenges such as limiting the ability to allocate tasks and specific responsibilities to individual staff members so as to promote responsibility and accountability.

Judgment: Not compliant

Regulation 16: Training and staff development

The internal review of June 2022 had found 11 staff members required a range of training and refresher training. This HIQA inspector reviewed the record of staff training for one of the two apartments. Some minimal progress had been made but refresher training in for example manual handling, responding to behaviour that challenged including positive interventions and de-escalation and intervention techniques was overdue.

Judgment: Substantially compliant

Regulation 23: Governance and management

Based on the evidence available to the inspector the provider failed to ensure governance arrangements were in place that ensured consistency and continuity of management and oversight particularly in response to unplanned absence. Staff spoken with described the challenge of not having available to them the strong guidance and support ordinarily provided by the person in charge. The most recent internal review highlighted the need for consistent governance arrangements. In addition, persons participating in the management of the centre were not always supported by working arrangements that allowed them to effectively fulfil their substantive role and responsibilities. Staff shortages and staffing arrangements meant both social care workers did not always have protected administration time. While the provider was collating data on the quality and safety on the service such as from formal and informal monitoring by the person in charge, from risk assessments, staff supervisions, feedback from representatives and residents, it was not evidenced how this data was effecting timely change and improvement. Collectively these findings highlighted the need for and the impact of not having in place consistent and effective governance and management. For example, the absence of continuous oversight including clinical and social care oversight. This was of concern given the complexity of this service and the fact that another planned absence was imminent.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents were supported to understand and access the providers complaint procedure if they wished. The inspector saw measures put in place in response to a complaint received. At the time of this inspection these supportive measures were ongoing, appeared to be effective and to the satisfaction of the resident. In feedback provided by representatives the inspector saw that representatives stated that when they raised concerns they were listened to.

Judgment: Compliant

Quality and safety

This service had the potential to be very good service and while there was evidence of good practice the issues referenced in the previous section of this report limited

the quality and safety of the service.

For example, to ensure resident well-being, timely completion of the assessment of compatibility that had been commenced by the person in charge was needed. The provider needed to assure itself and HIQA that it had the arrangements in place to meet the needs of residents individually and collectively. This included having the appropriate staffing levels and arrangements but also a suitable physical environment. For example, one resident had expressed dissatisfaction with the size of their bedroom. While of an adequate size it was much less spacious than the bedroom allocated to their peer. The limited space was compounded by the fact that the living space was shared and the resident kept a range of items such as musical equipment in their bedroom.

Residents did have opportunity to be out and about in their local community, to enjoy new activities and experiences but they also wanted to do different things to their peers. Residents did spend an amount of time living together in close proximity to each other in the apartments.

Staff described the shortfall in clinical input that had occurred from December 2021 to July 2021. Staff said that this may have contributed to the increase in expressed behaviors experienced by a resident. This was now addressed. For example, the inspector saw evidence of clinical input from psychology and psychiatry. However, this gap reinforced the need for consistent governance and consistent oversight including clinical oversight.

There were inconsistencies noted in the implementation of protocols and the personal plans for residents. For example a visual schedule put in place to support one resident was not consistently used and there were gaps in updating progress notes on personal plans. There was also gaps in the daily narrative notes in relation to the care and support offered to residents. There was evidence that the person in charge was monitoring and seeking to address these issues with the staff team.

Fire safety measures including a fire detection and alarm system, emergency lighting and fire-fighting equipment were in place. There was documentary evidence that these systems were inspected and serviced at the required intervals. As discussed in the opening section of this report a resident spoken with confirmed they left their apartment when the fire alarm activated. Simulated evacuation drills were completed and good evacuation times were reported. However, better oversight was needed of the simulated drills designed to test the effectiveness of the evacuation procedures.

There was evidence of practice that was consistent with the standards and national guidance on infection prevention and control. For example, the monitoring of resident and staff well-being each day, the wearing of face masks and attention to hand-hygiene. The inspector discussed the management of an outbreak of infection that had occurred. A staff member said they had followed the outbreak plan and received support and guidance from another person in charge. Staff could identify the possible source of accidental transmission to a social event and, the outbreak was controlled once detected. However, based on these inspection findings

improvement was needed to ensure residents were protected at all times from the risk of infection.

Regulation 26: Risk management procedures

Better oversight was needed of the identification and management of risks. For example, while a compatibility assessment was in progress there was no risk assessment in place capturing the impact and level of risk to resident well-being. Controls to manage an identified high risk were not consistently implemented. For example, existing controls is response to the risk posed to the quality and safety of the service included dedicated and protected administration time for the social care workers, regular staff team meetings and, the completion of the handover protocol. Failings with regard to these controls have been discussed in the body of this report

Judgment: Not compliant

Regulation 27: Protection against infection

Improvements were needed to ensure residents were at all times protected from the risk of preventable infection. One shower in one apartment was not working; this was a longstanding matter. This did not impact on residents as they both had an en-suite but it was not available to staff if needed. One bathroom was shared. The grouting of the shower was heavily stained and a large amount of personal toiletries were stored on the windowsill. This apartment did not have a utility space and the mops were stored in a cupboard in this shared bathroom. The hand-towel dispenser at one wash-hand basin was empty. Inconsistent attention to cleaning duties was reported and evident from records seen. For example, cleaning duties not being completed was discussed at a recent staff meeting and in the formal memos issued by the person in charge. There were gaps in the cleaning schedules seen by the inspector.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Based on the records made available to the inspector a review of the timing and intervals between simulated evacuation drills was needed. For example, while seven drills were recorded five of these were completed in June and July 2021 and none were completed again until April 2022. None of these drills tested the ability of one staff to evacuate all four residents. Only approximately 50% of the staff listed on

the staff rota had participated in these drills. It was evident that door wedges were used to hold open some fire resistant doors.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider was aware that there were issues of compatibility between residents. Given the expressed concerns from residents and the evidence gathered by the provider the provider needed to assure itself that it had the arrangements in place to meet the needs of residents individually and collectively. For example, it was explicitly recorded that a resident was finding it very difficult to get on with their peer. The person in charge had arranged for an MDT (multi-disciplinary team) review of the resident's personal plan, its appropriateness and effectiveness. The resident was supported to participate in this review. This review was recent and the formal record was awaited. The person in charge advised that the actions arising from the review included compatibility of needs, staffing arrangements and the suitability of the living arrangements in the context of differing needs and personalities.

The person in charge had ensured personal plans were in place for each resident. However, there was evidence that these plans were not always consistently implemented. For example, the inspector saw that while a template said a resident was to have their body weight monitored weekly no weight was recorded from May to August 2022. Feedback provided recently by a representative highlighted the need for more evening activities and queried why an agreed goal appeared to have ceased. The person in charge told the inspector that this was now being addressed. However, there were gaps in the daily support notes with regard to the progression of residents agreed goals and objectives

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Newmarket Residential OSV-0005528

Inspection ID: MON-0037802

Date of inspection: 29/08/2022

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:
PIC and PPIM will review staffing arrangements to ensure that the hours required/contracted to deliver services and supports (rostered Hours) are been maintained.

PIC and PPIM will review staffing arrangements to ensure all core staff work within this designated centre only.

In addition PIC & PPIM in consultation with HR will recruit additional relief staff for this DC.

An additional 2 days support and evening support has been put in place to provide one to one support where incompatibility issues have been identified.

A further increase of staffing supports across day and evening will be identified and sanctioned to provide one to one support where compatibility issues have been identified to include a focus on evening activities.

PIC & PPIM will explore further options and strategies to address issue of loneliness for individuals in the apartment.

A staff contingency plan will be put in place to address absences at short notice, which protects administration time for SCW, thereby ensuring consistent management and oversight of the service.

A team meeting will be convened at which the Clare Services Manager will discuss recent inspection report, and the actions necessary to resolve the issues highlighted in the report such as team dynamics and culture, staff responsibilities and accountability in the DC

PIC, PPIM in consultation with HR manager will directly address staffing issues within the team, a plan will be put in place and progress monitored. Where deemed necessary, specific training and/or other HR interventions, will be identified to assist in addressing such issues.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
PIC in consultation with Training will ensure that staff training gaps identified in the internal review are addressed.

Training Matrix has been reviewed and updated to clearly identify and include up to date training records for all staff rostered.

Training matrix will be subject to ongoing review by SCW and monitored by PIC.

Site specific training such as Code of Practice, Individual Planning, Report Writing, Risk Management, Dignity at Work, Positive Behaviour Support will be delivered to the staff team.

PIC, PPIM in consultation with Training and HR will measure the effectiveness of the training outcomes in terms of implementing organizational practices and processes.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PIC and PPIM will review staffing arrangements to ensure that the hours required/contracted to deliver services and supports (rostered Hours) are been maintained.

PIC and PPIM will review staffing arrangements to ensure all core staff work within this designated centre only.

In addition PIC & PPIM in consultation with HR will recruit additional relief staff for this DC.

A staff contingency plan will be put in place to address absences at short notice, which protects administration time for SCW, thereby ensuring consistent management and oversight of the service.

A team meeting will be convened at which the Clare Services Manager will discuss recent inspection report, and the actions necessary to resolve the issues highlighted in the report such as team dynamics and culture, staff responsibilities and accountability in the DC

PIC, PPIM in consultation with HR manager will directly address staffing issues within the team, a plan will be put in place and progress monitored. Where deemed necessary, specific training and/or other HR interventions, will be identified to assist in addressing such issues.

PIC will continue to review all documents related to individuals where staff have responsibility to update such as daily logs, personal activities, and cleaning schedules to ensure consistency.

A contingency plan will be developed to address planned/unplanned absences of a PIC. The plan will detail
• responsibilities of SCW and PPIM during short term and long term absences.
• Supervision of staff during short and long term absences
• how strong guidance and support will be maintained for staff covering the PIC role during short and long term absences.

PIC and PPIM will ensure the completion of a detailed compatibility assessment that is informed by an Independent advocate representing the needs of the individual who has indicated a dissatisfaction with current living arrangement and the services and supports been provided.

Based on the compatibility assessment a business case will be submitted to the HSE to address assessment outcome.

PIC & PPIM will request further behavior support intervention for the staff team.

PIC & PPIM will develop a management and governance plan outlining roles and responsibilities to cover upcoming planned PIC absence.

PPIM will put in place a mentorship process to support new PIC covering upcoming planned absence to include minuted meetings on a fortnightly basis with action plan.

PIC will work from the DC at least 3 days a week allowing for clearer oversight, governance and management of the DC.
Team meetings will take place on a monthly basis. PIC will ensure that all staff attend team meetings.
PPIM will ensure that all data collected is analysed all systems and processes are reviewed, all audit action plans are progressed and implemented to assure the quality and safety of the service and drive continuous improvement.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk assessment will be completed for staff supervision and where risk rating indicated a red risk will be escalated in line with Risk Management Policy

Risk assessment will be completed on compatibility of two individuals that will capture the impact and level of risk to resident wellbeing, detail the control measures in place and additional control measures needed to mitigate against the risk. Where the risk rating indicated a red risk the risk will be escalated in line with Risk Management Policy.

Risk Assessment titled Poor Quality of Service will be updated and reviewed fortnightly to ensure (a) the control measures such as protected admin time for SCW, team meetings and handover protocol are consistently been implemented and (b) additional measures are put in place where necessary to mitigate the risk.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
PIC & PPIM will ensure the local IPC procedures are implemented across both apartments

Person In Charge will ensure maintenance and storage issues that impact on IPC are resolved eg working shower, grout and suitable storage for personal toiletries and mops.
All staff team to complete AMRIC Cleaning & Disinfecting the Healthcare Environment and Patient Equipment on HSELand before the end of October 2022.
PIC and PPIM to introduce processes to ensure consistent attention by all staff to cleaning duties, replenishing of supplies and completion of cleaning schedules. Failure to implement good cleaning practices and IPC measures will be addressed through the HR process.
Specific cleaning rosters will be introduced for each room.
PIC & PPIM will ensure more regular spot checks and Infection Control Audits are carried out to assess improvements in implementing IPC measures. The IPC risk assessment will be reviewed and updated to reflect such additional controls and more frequent

timeframes.
PIC will ensure there is increased focus on IPC on all team meetings.
Team meetings will take place on a monthly basis. PIC will ensure that all staff attend team meetings.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
PIC will ensure fire drill tests the ability of one staff to evacuate all four residents.
Completed on: 09/09/2022

PIC will ensure fire drills as per schedule will be completed.
Completed on: 22/09/2022

PIC will prepare guidance for staff on conducting a simulated fire drill.

All remaining staff on team will have completed a simulated drill by 07/10/2022 and records of such will be available in the Fire Folder.

PIC will review all records of simulated drills as part of the quarterly reviews and ensure that all staff have completed a fire drill, that adequate records are maintained and the required number of fire drills will have taken place within that quarter. PIC will ensure that any recommendations arising from this quarterly review are implemented and associated documentation is updated.

PIC will ensure that door closure is placed on the staff office door.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
PIC and PPIM will ensure the completion of a detailed compatibility assessment that is informed by an Independent advocate representing the needs of the individual who has indicated a dissatisfaction with current living arrangement and the services and supports been provided.

The individual plan will be reviewed and updated to reflect the individuals wishes based on the compatibility assessment and input from MDT.

All staff will attend training on personal planning that includes goal setting and achieving goals.
PIC and SCW will monitor staff and daily activities to ensure there are no inconsistencies between individual plans and daily activities. Failure to implement actions and meet goals as outlined in plans will be addressed through the HR process.
PIC & SCW will ensure that the correct version of planning and support note templates are been completed by staff.

A further increase of staffing supports across day and evening will be identified and sanctioned to provide one to one support where compatibility issues have been identified to include a focus on evening activities.

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	Orange	23/12/2022
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	23/12/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	23/12/2022

	training, including refresher training, as part of a continuous professional development programme.			
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	Orange	23/12/2022
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	Orange	23/12/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Not Compliant	Orange	31/10/2022

	ongoing review of 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.	Substantially Compliant	Yellow	30/11/2022
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.	Substantially Compliant	Yellow	31/10/2022
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each	Not Compliant	Orange	31/03/2023

	resident, as assessed in accordance with paragraph (1).			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	31/03/2023