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:	Pinewood Lodge
Name of provider:	Dundas Unlimited Company
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	24 January 2023
Centre ID:	OSV-0005551
Fieldwork ID:	MON-0029860

About the designated centre

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

The centre is located a short distance from a town in county Meath. It aims to provide a residential service for up to 6 adults both male and female over the age of 18 years diagnosed with intellectual disabilities, autism, acquired brain injuries and who may also have mental health difficulties. It is the aim of the service to promote independence and to maximise quality of life through person centred principles within the framework of positive behaviour support. The centre is a two storey detached building consisting of six bedrooms, one of which has an en-suite bathroom. There is a kitchen, utility room, large dining room/conservatory, two other communal recreational rooms, two bathrooms and one wc. There is a large garden to the front and back of the property and a garage. The centre is staffed by team leads, direct support workers and a person in charge. Four of the residents do not attend a formal day service and one resident attends a day service some days. The staff team support residents to have a meaningful day by planning activities that residents like to do on a daily basis. A car is provided in the centre for residents to attend appointments and go on chosen activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Tuesday 24 January 2023	10:30hrs to 19:45hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

This was an announced inspection carried out in advance of a registration renewal of the centre. The inspector found that improvements were required in a number of regulations inspected so as to ensure that residents received a safe quality service.

On arrival to the centre a staff member went through some questions regarding infection prevention and control (IPC) with the inspector.

Over the course of the inspection, the inspector met all of the residents who lived here. Two of the residents agreed to meet with the inspector to talk about what it was like to live in the centre. As part of the inspection, the Health Information and Quality Authority (HIQA) also had sent a number of questionnaires for residents or their representatives to complete. These questionnaires were designed to collect information about the residents views on the quality and safety of care provided.

All of the residents had completed a questionnaire, some with the support of staff members. Overall, the feedback from these questionnaires was positive in terms of the staff being kind and helpful, making a complaint and feeling safe in the centre. The residents who met with the inspector also said that they liked their home and liked the staff. However, all of the residents questionnaires provided reported some improvements they would like to see happening to improve their quality of life. The following describes their views. Two residents said they would like access to more activities outside and inside the centre. One resident said they would like it if staff could listen to them more. One resident said that sometimes staff don't understand the words they are saying. One resident said that they would like to change their food and another said they would like their meals served later in the day and to be involved in preparing some of the meals. One resident commented that they would like more 'quietness' in the centre. Two residents also said that they would like the environment to be less noisy. The inspector informed the person in charge and the assistant director of care about the feedback from residents both of whom assured the inspector that they would address this feedback with all of the residents.

In addition to this, the inspector followed up on some of the issues raised by the residents and found that improvements were required in some of the areas highlighted by the residents. For example; the inspector reviewed the complaints process, residents access to activities inside and outside the centre and found that significant improvements were required. This is discussed later in the report.

The centre was large and spacious and, each resident had their own bedroom. However, the inspector observed while walking around the centre, that improvements were required in some areas. Some of the issues had either not been identified by the provider or had been highlighted through audits; but the actions had not been completed in a timely manner. For example; one residents bedroom had mould around the window and the window blind was dirty. This had not been highlighted through the providers own audits. This is discussed in more detail under

premises later in the report.

As stated, all of the residents provided feedback on the complaints process in the centre and said they would report concerns to the person in charge or a staff member. One resident said that they were happy with the outcome of a complaint when they had made one. However, the inspector reviewed a number of complaints that residents had made about noise levels in the centre and was not satisfied that the complaints raised were dealt with in a respectful, confidential and effective manner. For example; the residents who made the complaints were required to take actions to alleviate their anxieties when the noise was affecting them. So the residents who made the complaints had to leave the centre for a walk or activity, have their meals in the sitting room or go to their room or a relaxation room when the noise was too much for them. The inspector observed these practices in the centre on the day of the inspection. In addition, in the written response from the provider to the residents (the complainants) the author of the letter had included personal information relating to another resident in the centre. This was not respecting that residents right to privacy.

Residents meetings were held in the centre along with key working meetings with each resident. This was an opportunity for residents to be included and informed about things that were happening in the centre. The inspector found that residents could attend the meeting if they chose to. Items discussed included menu plans activities, fire safety and staying safe in the centre. Residents were supported to keep in contact with family and one resident spoke about visiting family over the Christmas period.

At key worker meetings, residents discussed some of their goals for the month ahead. Some residents had been on overnight stays last year in a hotel or had celebrated significant birthdays. However, a review of some residents goals found that improvements were required. For example; one resident had a goal to go to the zoo this month and at the time of the inspection there was no plan to achieve this goal.

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

Capacity and capability

Overall the governance and managements systems in place were not always assuring a safe, quality service to the residents living in the centre. This resulted in a number of improvements required in complaints, fire safety, general welfare and development and the premises. Some improvements were also required in personal plans, safeguarding, IPC and risk management.

While there was defined management structure in place at the time of the inspection. The systems in place to review and measure the safety and quality of care in the centre were not highlighting some of the issues identified on this inspection and where they were highlighted some were not addressed in a timely manner. For example; on the day of the inspection improvements were required to the premises, fire safety and residents access to activities inside and outside the centre.

The management of complaints also required significant review to assure that concerns were dealt with in a fair, effective and respectful manner.

Staff had been provided with mandatory training and other training in order to meet the assessed needs of the residents. Regular staff meetings were held in the centre and staff received supervision where they could raise concerns.

The staffing levels and skill mix were in line with the statement of purpose of the centre at the time of the inspection. Three staff were on duty every day and two waking night staff were on duty.

Improvements were required in the contingency risk assessments that the provider had in place should a shortfall of staff arise in the centre and with the records stored in personnel files.

There were no volunteers employed in the centre.

Regulation 14: Persons in charge

The person in charge had the necessary skills and management experience as required under the regulations. They were employed on a full time basis and worked solely in this centre. They facilitated the inspection and were found to be transparent in their dealings with the inspector. They had a good knowledge of the residents needs in the centre.

Judgment: Compliant

Regulation 15: Staffing

The number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

There was a planned and actual roster maintained in the centre. This was maintained on a computer system in order to ensure accuracy. However, it was unclear from the rota who was a permanent member of staff and who was a relief

staff member. The person in charge agreed to bring this back to the management team for review.

The provider had a risk assessment in place to identify the control measures in place should there be a shortage of staff in the centre. For example; the provider had assessed that where there was a shortfall of staff in the centre, two staff instead of three staff on days and one waking night staff and one sleepover staff would suffice. However, the risk assessment did provide assurances that residents needs could be met should a shortfall of staff occur in the centre.

A sample of staff personnel files reviewed were found to contain most of the requirements of the regulations. However, one staff file did not have a full employment history, together with a satisfactory history of any gaps in employment. This is a requirement under schedule 2 of the regulations.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of a sample of training records showed that staff employed on a full time basis had received training in fire safety, manual handling, safeguarding vulnerable adults, medicine management, first aid, infection prevention and control, positive behaviour support, and person centred care.

All new staff received induction training in the wider organisation and in the designated centre when they started working in the centre.

Regular staff meetings were held and the person in charge ensured supervision of staff took place regularly. Staff informed the inspector that they felt supported in their role and that they had no concerns about the quality and safety of care being provided. They informed the inspector that should concerns arise they could talk to managers daily or through supervision.

Judgment: Compliant

Regulation 22: Insurance

The provider submitted up-to-date insurance details for the centre as required by regulations.

Judgment: Compliant

Regulation 23: Governance and management

There was defined management structure in place at the time of the inspection and systems in place to review the quality of care and safety of residents in the centre. However, given the findings of this inspection, the inspector was not assured that the provider had appropriate mechanisms in place to ensure that safeguarding plans were reviewed to ensure that they were effective; and that complaints were managed or reviewed to assure that residents concerns were acted on appropriately.

While audits were conducted in the centre some of which included health and safety and IPC, and fire safety, these audits had not highlighted the mould observed in the centre, or the issues identified with fire safety on the day of the inspection. Some actions from audits had also not been completed in a timely manner. For example, a small wall made up of pillars was broken in the garden. This was due to be completed by 16 Jan 2023 and had not been done at the time of the inspection.

An unannounced quality and safety review had been conducted on 6 January 2023. The action plan dates for completion were incorrect as they were dated for completion on 31/12/2022. It was not clear when these actions were due to be completed. For example; it had been highlighted at the review that there was notable gaps in the documents to ensure that residents planned goals were progressing. This had also been included as an issue in the annual review for the centre dated 01 August 2022 and was a finding at this inspection also. This needed to be reviewed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The inspector reviewed the statement of purpose and was satisfied that it met the requirements of the Regulations. It also detailed the facilities and services which were to be provided to residents.

Judgment: Compliant

Regulation 31: Notification of incidents

From a review of incidents that had occurred in the centre over the last six months, the inspector was satisfied that the person in charge had notified the chief inspector of any adverse incidents that happened in the centre as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

A number of complaints had been raised by two residents last year which related to noise levels in the centre. The records maintained in relation to this were not complete on the day of the inspection and the inspector was not assured that the complainants were satisfied with the outcome. For example; in written feedback one resident stated that they were not happy with the noise levels and the two residents who the inspector met said they did not like the noise levels in the centre. This was particularly concerning as both residents assessed needs stated that they needed to live in a quiet environment due to their anxieties.

In addition, the actions taken by the registered provider to address the noise complaints required the residents who made the complaints to leave the centre if the noise levels caused them anxiety and two other residents were required to have their meals in the sitting room.

The inspector was not assured that the complaints raised were dealt with a respectful, confidential and effective manner.

Judgment: Not compliant

Quality and safety

Overall the inspector found from talking to residents, reviewing their feedback, observing practices in the centre and talking to staff that the quality of life of residents living in the centre needed to be improved. Some improvements were also required to the systems in place to keep residents safe including, fire safety and risk management.

The fire safety systems in place on the day of the inspection could not assure a safe evacuation of the centre in the event of a fire. Staff spoken to were not clear about some of the fire safety measures in place. The provider was requested to submit assurances around some fire safety issues the day after the inspection.

The premises were spacious and communal areas were generally clean. However, the inspector identified a number of issues with the premises in terms of accessibility for residents, and maintenance and cleanliness issues on the day of the inspection.

Each resident had a personal plan in place which included an assessment of need. Support plans were in place to guide practice. However, one staff member spoken

with was not aware of one residents health care condition and the recommendations from a review conducted in December 2022 for one resident had not been followed up at the time of the inspection.

Residents health care needs were supported, however, improvements were required in one residents' assessed health care need.

The inspector observed that residents had limited access to activities inside and outside the centre some days and improvements were required in the goals that residents planned each month to ensure that they were completed.

The registered provider had systems in place to manage risk in the centre. However, some improvements were required in this area.

Regulation 13: General welfare and development

The inspector was not satisfied from talking to residents, reviewing their feedback on the services provided and observing the practices in the centre on the day of the inspection that the registered provider had provided access to facilities for occupation and recreation and opportunities for residents to participate in activities in accordance with their interests. For example; on the day of the inspection one resident went out on and returned to the centre around lunch time. Other than listening to music there was no other activities planned for the resident that day. Two other residents were observed spending most of the day in a relaxation room listening to music. One went for coffee late afternoon and the other resident went for a drive in the evening time.

The inspector also observed from audits conducted in the centre that residents goals needed to be improved in the centre. Residents planned their goals on a monthly basis at key working meetings. However, on review of two residents goals for January 2023, there was no plan in place to achieve these goals by the end of the month. One residents goal was to go to the zoo. The inspector also noted that some months residents did not have goals set. For example; there were no goals set for one resident between September 2022 and December 2022.

Judgment: Not compliant

Regulation 17: Premises

The premises were large, spacious and each resident had their own bedroom. Some of the residents had recently had their bedrooms painted.

The outside area was not maintained very well. A wall to the back of the property was broken. There was moss accumulated on the outside entrance area which could

pose a potential trip hazard to one resident in particular. A section of the roof also had moss accumulated.

On a walk around of the centre some areas of mould were identified in two residents bedrooms. One around the window and one on the ceiling. In one residents bedroom the blind was visibly dirty. In two of the bathrooms some of the skirting boards were not properly secured to the wall.

In one bathroom seals around the floor were worn and had come away from the wall.

A wooden floor in the kitchen area was worn in large areas. The registered provider had identified this in an audit of the centre. The staff informed the inspector that the floor had recently been varnished, however the floor was not finished to a good standard.

Some residents did not have access to part of their home due to the ongoing issue with noise levels in the centre. For example; two residents ate their meals in the sitting room at a small dining table.

The front entrance to the property needed to be reviewed as one resident would not be able to egress the centre in the event of a fire in a wheelchair.

Judgment: Not compliant

Regulation 18: Food and nutrition

There were sufficient quantities of food and drink available in the centre on the day of the inspection. Residents got together every week to plan the menu for the week. As discussed in the first section of the report one resident said that they would like to be involved in preparing more of their meals and one resident said that they would like to have a preference for the times that meals were served which the person in charge intended to follow up on these issues with residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place. When incidents occurred in the centre they were reviewed by the person in charge and control measures were outlined on this review to mitigate risks. However, one risk assessment had not been updated to include the additional control measures proposed following a review of two incidents where a resident had sustained an

injury. This required review.

The vehicles used to transport residents was insured and roadworthy at the time of the inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Staff were observed to wear appropriate personal protective equipment in line with public health guidelines and there was a sufficient supply of personal protective equipment (PPE) in the centre. The provider had a contingency plan in place to manage and outbreak of COVID-19 and influenza in the centre.

Enhanced cleaning schedules were in place which were being completed by staff to mitigate the risk of cross contamination. There were procedures in place to manage laundry and staff were aware of these procedures.

Since the last inspection there had been no outbreaks or cases of COVID -19 in the centre.

However, as discussed under premises, the inspector was not assured that audits conducted in relation to infection prevention and control were identifying issues observed on this inspection that related to mould. This required review.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place to manage a fire in the centre. However, significant improvements were required to some of those systems. For example; it had been identified by the provider that two residents may not evacuate the building during a fire. In this instance staff were to employ an approved transport technique to support the resident to evacuate. However, when the inspector reviewed the lay out of the centre and asked staff to demonstrate how this would occur, it was not physically possible to implement this technique. This required review.

In addition, the inspector was not assured from speaking to staff member that they were fully aware of all of the fire precautions in place.

Perspex panels were attached to banister of the stairs. The inspector sought assurances about this to assure it was fire compliant, the records were not available to confirm this on the day of the inspection. Verbal assurances were provided and written assurances were submitted by the registered provider the day after the

inspection confirming that they were satisfied that the panels were fire resistant. The provider also submitted additional assurances around other actions they had taken to address the fire safety issues identified on the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place which included an assessment of need. Support plans were in place to guide practice. The assessment of need was reviewed by the allied health professionals involved in the residents care on an annual basis. However, a recommendation for one resident following this review in December 2022, to be referred to a speech and language therapist had not been completed at the time of this inspection. And one staff spoken to was not aware of one residents health care condition.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a number of allied health professionals and medical doctors to support their health care needs.

At the time of the inspection it had not been confirmed whether a resident had a specific health care condition, even though they had been living in the centre since 2019 and this health care need was written in their assessment of need. The person in charge was following up on this at the time of the inspection, however given the length of time the resident was living in the centre, the inspector was not assured how the registered provider was providing appropriate health care for this resident at the time of the inspection.

Judgment: Substantially compliant

Regulation 8: Protection

All staff had been provided with training in safeguarding vulnerable adults. Residents reported that they felt safe in the centre and would report concerns to the staff. The staff were aware of the different types of abuse and the reporting procedures to follow in the event of suspected safeguarding concerns.

The registered provider had notified HIQA on a number of occasions in 2022 of

allegations of abuse which related to the impact of other residents behaviours in the centre. At that time the provider had notified the relevant authorities and implemented interim safeguarding plans to protect residents. However, these safeguarding plans had not been effectively reviewed to assure the provider that the measures in place were effective. As discussed under complaints and premises some of the interim safeguarding measures meant that the residents affected had to change their routines to reduce the impact of noise levels on them.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Pinewood Lodge OSV-0005551

Inspection ID: MON-0029860

Date of inspection: 24/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
A review of The Talbot Groups staff time management system, which produces staff Rota's has been conducted by the Management Information System Project Manager. The purpose of this review is to review the system's ability to identify on the Rota if a staff member is permanent, part time or relief.

A review of staffing contingency measures has been conducted. Arrangements are in place to respond quickly to staff shortages to ensure continuity and appropriate care. These arrangements include,

• The Person in Charge will continue to utilize the planned and actual staff rosters, to identify staffing requirements. The relief panel will be contacted to fill shifts as required. The Talbot Group currently have access to over 133 staff members who are willing to complete relief hours.
• An overtime initiative is also available to all staff within the Talbot Group, to enhance the organizations staff contingency arrangements. This initiative will be used as a contingency arrangement and in accordance with the working time Act.
• Additionally, this centre benefits from a Supernumerary Person in Charge and in the event of an unplanned absence, the Person in Charge can be used to supplement front line staffing arrangements.

A review of all staff personnel files within the centre has been conducted by a Human Resource representative, any gaps in this information has been addressed and these files are now in compliance with Schedule 2 of the Regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of the centers Governance and Management Arrangements has been completed. To strengthen the arrangements in place a provider led improvement plan has been put in place. This plan includes.

• A mentoring program for the Person in Charge, with an experienced Person in Charge.
• All Assistant Directors of Service and the Director of Operations completed Audit training on the 21st of February 2023. The focus of this training was on the importance of self-identifying and escalating areas of concern. This will ensure that where concerns are raised the necessary measures can be put in place in a timely manner.
• An enhanced Governance Monitoring & Assurance Arrangement has been implemented within Pinewood Lodge. This includes a weekly on-site visit of the center by the Director of Operations (DOO). These visits will continue until the DOO is satisfied the centre is in compliance with the regulations. This will be kept under monthly review.
• A review of the effectiveness of all safeguarding plans has been completed, to ensure all measures implemented are effective.
• A review of all complaints and the measures put in place to address complaints has been completed, to ensure that the measures taken bring positive change within the centre.
• The completion of an unannounced IPC audit and the development of a quality improvement plan.
• A full premises review has been completed by the Facilities manager.
• A weekly report has been developed by the DOO, focusing on ensuring all actions from the relevant reviews have been addressed. This report is escalated to the Chief Operations Officer and shared with the Chief Executive Officer weekly.
• The unannounced quality and safety review system utilized for the Talbot Group has been modified by the Management Information System Project Manager to ensure that the actual audit date and the audit publishing date are clearly distinguishable.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A review of the complaints made within the centre has been conducted with a focus on ensuring that the measures being implemented addressed the concerns raised by the complainants.
This review resulted in the overall compatibility within the centre being reviewed on 26th of January 2023 and a process is now in place to support a resident move to a center that will meet their assessed needs.

All staff within the centre will be required to complete HSE Effective Complaints Handling. To ensure complaints are addressed respectfully, confidentially and effectively.

A complaints escalation pathway is in place to ensure where complaints cannot be addressed locally that they are managed in line with the Talbot Groups policy on Complaints. These complaints will be monitored for trends during monthly Governance meetings.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A review of the arrangements in place to ensure residents have access to facilities for occupation and recreation in line with their preferences has been completed. Activity scheduling will be completed weekly and in consultation with residents. The plan will be cognisant of the necessary resources required to fulfill the weekly plans. This schedule and its effectiveness is monitored weekly by the DOO during weekly governance meetings.

In addition, all staff and the Person in Charge will be required to complete in person Keyworker training. The purpose of this training will be to ensure all staff understand the importance of goal planning with residents. All goals will be monitored to ensure there is appropriate planning and implementation of the documented plans. This will form part of the weekly governance review.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review of the premises was completed by the Director of Operation and Procurement & Estate Manager. Furthermore, an unannounced IPC audit was conducted in the centre on the 22.02.2023.

The following actions were completed.

• The wall to the rear of the property has been rebuilt.
• The moss accumulated on the outside entrance area has been treated and removed.
• Areas where mold were identified in residents' bedrooms has been cleaned. Including around the window and on the ceiling.

• The blind has been removed and replaced.
• Any skirting boards that were loose have been secured.
• In one-bathroom seals around the floor were worn and had come away from the wall, these have been repaired.
• The wooden floor in the dining area was replaced.
• The front entrance to the property was reviewed by the Occupational Therapy Manager to ensure all residents could safely egress from the centre in the event of a fire.
• The moss on the roof will be removed when the weather improves and it's safe to do so. This will be completed by the 31st of March 2023.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A review of the risk assessment in question was completed by the Person in Charge and the required additional control measures were added to the risk assessment. All staff have been informed of the additional control measures and are actively monitoring to reduce the likelihood of a recurrence of this type of incident.

The enhanced governance arrangements in the centre will ensure the timely implementation risk assessment reviews. Particularly where learning from an incident necessitates an update to control measure.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
A full unannounced IPC audit was completed within the centre on 22.02.23. This audit was an assessment of Regulation 27 to 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. Any actions identified from this audit will be actioned and progress with these actions will be monitored weekly by the Director of Operations and shared with the COO.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The overall systems to manage a fire in the centre were reviewed.
Since the inspection, all residents have safely evacuated the centre during planned fire drills. Individualised supports were put in place for resident's who previously refused to evacuate during simulations, to ensure they can be safely evacuated in the event of a fire. Each residents Personal Emergency Evacuation Plan (PEEP) has been updated to reflect the specific supports required for each resident.
In relation to the polycarbonate covering used on the Banisters of the stairs. The material is suitable for its intended use on the stairs and does not pose fire hazard. These assurances were provided post inspection and the supporting documentation is now in place within the centre.

All staff have refreshed there in Person and Theory Fire safety training. Additionally, regular fire evacuations have been completed with staff to ensure they understand all aspects of the fire evacuation process and are familiar with all firefighting & safety equipment available within the centre.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A review of each resident's assessment of need has been completed and all actions identified from these assessments have now been actioned. This includes the referral of a resident to Speech & Language.

The enhanced governance arrangements in the centre will ensure that any actions identified from residents assessments are actioned in a timely manner.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A full review of this resident's healthcare history was completed by the Person in Charge, in consultation with the residents General Practitioner. This involved the review of

medical notes from over a decade, that were held with another GP. The outcome of this review found that the residents health condition is not a systemic condition and will only require treatment if the residents presentation changes. Guidance in this regard will be led by the residents GP.

A healthcare plan has been included on the residents personal plan, to ensure staff are aware of this residents medical history and what intervention is needed if their presentation changes.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A review of the current protection measures within the centre have been reviewed and will be kept under active review during weekly governance, to ensure that all measures contained within the safeguarding plans are effective and appropriate.

Interim safeguarding measures in place will not consist of affected residents having to change their routines to reduce the impact of noise levels on them. Any proactive and reactive measures implemented, will focus on supporting the resident of concern, to limit the impact of their presentation upon peers.

A transition plan is in place to support a resident to live in a center that meets their assessed needs.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	13/03/2023
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	13/03/2023
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	Substantially Compliant	Yellow	31/03/2023

	basis.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	28/02/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2023
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	28/02/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	22/02/2023

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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 risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	28/02/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	22/03/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in	Not Compliant	Orange	28/02/2023

	place.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	28/02/2023
Regulation 34(4)	The registered provider shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.	Not Compliant	Orange	28/02/2023
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.	Substantially Compliant	Yellow	28/02/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	03/03/2023
Regulation 08(2)	The registered	Substantially	Yellow	03/03/2023

	provider shall protect residents from all forms of abuse.	Compliant		