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:	Delvin Centre 4
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	13 February 2024
Centre ID:	OSV-0007483
Fieldwork ID:	MON-0039207

About the designated centre

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

Delvin Centre 4 is a bungalow located near a town in Co Westmeath. The house is specifically designed to encompass two self-contained apartments. The house has both front and rear outdoor space, which is fenced off.
Both apartments have two separate access doors. Apartment A is located to the front of the building and contains a kitchen, sitting room and a corridor leading to a bathroom and bedroom. The bathroom provides shower facilities.
Apartment B is located to the left of the building and runs to the back of the house. Apartment B contains a kitchen, utility room, sitting room, a bedroom, and a bedroom cum office.
The centre supports individuals with moderate-to-severe intellectual disability with specific support needs and is led by a person in charge and assisted by social care workers and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 13 February 2024	10:35hrs to 18:50hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, from what the inspector was told and what was observed, residents received person-centred care which was meeting their assessed needs. Significant progress was made in the reduction of restrictive practices in the centre which greatly improved access for one resident in their home, which in turn improved fire safety arrangements and improved the appearance of their home.

Notwithstanding this, significant improvements were required in general welfare and development and staffing. In addition, improvements were required in relation to training and staff development, individualised assessment and personal plan, protection against infection and fire precautions. These areas are discussed further in the next sections of the report.

The inspector had the opportunity to meet both residents that lived in the centre. For the most part, residents had alternative communication methods and they did not share their views with the inspector.

One of the residents did interact with the inspector in their home and were observed smiling. The inspector observed gentle and calm interactions with the staff member on duty towards the resident and they were observed responding quickly to the resident's communication cues. This resident went out for the day to a different town to attend a sensory room, go shopping and have lunch. The staff member communicated that they had a nice day and that the resident appeared in good form all day.

The other resident, due to not having enough staff support, remained in the centre for the day of the inspection. They were supported to have a bath, use some of their favourite objects and played with their soft toys. They appeared relaxed in the presence of the staff member supporting them. The staff member was heard on different occasions speaking in a respectful manner to the resident and responding to their requests. The inspector had a brief chat with the resident and they spoke about topics that they wanted to talk about at that time.

The centre was made up of two apartments beside one another with one resident living in each apartment. Both apartments were observed to be clean and tidy and there was adequate space for privacy and recreation. One resident's bedroom had recently been painted and there was a plan in place for the other resident to be supported to redecorate their room to suit more of their known preferences. In the meantime, they were recently supported to purchase a larger bed and they appeared to enjoy having more space to relax on. As previously stated, due to the reduction in many restrictive practices in place for one resident, their apartment was observed to be a more home like environment.

The property had a shared front garden and each resident had their own small back garden. However, these were not very inviting spaces as they did not have any

plants or decoration. One resident had a chair for relaxing in the garden; however, it was blocked by a lot of scattered bins and was inaccessible. Both the team leader and the centre manager communicated that they had already discussed this with the staff team and there were plans to make the spaces more inviting for the residents in order for them to make use of the gardens.

One resident had a trike for use in their back garden and in local parks. Each resident had their own separate transport in order to access external activities and appointments.

Both residents had their own separate staff team to support them. There was one staff member working in each apartment on the day of inspection. For the most part, staff spoken with demonstrated that they were familiar with the residents' care and support needs and preferences. They were observed to engage with residents in a relaxed way that was friendly and attentive. Staff were observed to communicate with residents in a respectful manner and tone that was responsive to their needs and preferences.

The provider had arranged for the majority of staff to have training in human rights. The inspector spoke with one staff member and they were asked how they were putting that training into everyday practice to promote the rights of the residents. They said that they were trying to involve the resident more while out in the community in order to promote their community presence. For example, supporting the resident to interact with a sales assistant and for the resident to hand over the money when paying.

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

Capacity and capability

The inspector found there were management arrangements in place to ensure safe care was being delivered to the residents and to meet their assessed needs. However, improvements were required to ensure the centre had adequate staffing levels each day and to ensure staff training and supervision had appropriate oversight and is up to date.

There was a defined management structure that included a suitably qualified and experienced person in charge.

The provider had carried out unannounced visits on a six-monthly basis as required. The six-monthly visits identified many of the areas highlighted on this inspection. There were other local audits completed in areas, such as medication.

The inspector reviewed a sample of rosters and found that while the provider was

actively recruiting, the centre did not have the full required staffing complement. This significantly impacted one resident in particular as they could not leave their apartment, other than to use their back garden, without a second support staff .

Staff had access to a suite of training and development opportunities to ensure they had the knowledge and skills to adequately support the residents for example, staff had training in fire safety. However, some staff training and refresher training was required, for example some staff required training in positive behaviour supports including de-escalation techniques, which was required to support the residents. In addition, not all training could be verified as having been completed and staff formal supervision was not occurring as frequently as was considered best practice by the provider.

Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity in the organisation and had the experience and qualifications to fulfil the role. They were the area director and were filling the role of the person in charge until a suitable candidate was found to replace them as the person in charge for this centre. Due to the remit of the area director they were supported in the day-to-day running of this centre by a team leader who split their time between several of the organisation's centres.

Staff members spoken with said they felt could bring any concerns to the team leader, or the person in charge. They communicated that they felt listened to.

Judgment: Compliant

Regulation 15: Staffing

The inspector observed there was an actual and planned roster in place. However, as with the last inspection of this centre they were operating below their whole-time equivalent (WTE) which mostly impacted the residents' additional support staff hours.

The current WTE of staffing was not adequate in ensuring one resident could leave their apartment other than to go in their back garden as two staff members were required to support the resident to attend any outings. For example, from a review of a seven week period of the roster the resident only had additional support hours that enabled them to leave their apartment for 27 out of 49 days. The other resident required additional support staff in order to go on longer outings. Therefore, the inspector was not assured that the provider’s workforce contingency plans were always effective.

There was an over-reliance on relief and agency staff, albeit consistent staff, to fill

rostered shifts. The provider communicated that they were actively recruiting in order to fill the vacant posts and once those posts were filled this would provide further continuity of care for residents.

Staff personal files were not reviewed on this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to training and development opportunities in order to carry out their roles effectively. The inspector noted some improvement in training and staff development since the last inspection. For example, all staff had fire safety training and medication management since the last inspection.

However, further improvements were still required. For example, one staff member's safeguarding training had expired in November 2023 and it was not discovered by centre management until the day of the inspection. The team leader had arranged for the staff member to complete the training on the day of the inspection. However, the inspector was not assured that there was always appropriate oversight over staff training in order to ensure staff received their training prior to it expiring.

The inspector found that not all training could be verified on the day of the inspection by way of training certification or the training oversight document. For example,

- with regard to some staff members' safeguarding training
- there was no evidence presented to the inspector to verify that staff had training in standard and transmission based precautions for infection control.

Other identified area included:

- a number of staff required hand hygiene refresher training
- a number of staff required personal protective equipment (PPE) refresher training
- a number of staff required first aid or cardiopulmonary resuscitation (CPR) refresher training as they were lone working at night and on some days
- some staff required refresher training in respiratory hygiene and cough etiquette
- some staff required training or refresher training in positive behaviour support that included de-escalation techniques which was required in order to support the residents to manage their behaviour positively
- there was no evidence that one staff had training in emergency rescue medication for epilepsy which was required for the resident that they supported.

In addition, while staff had received some formal supervision in 2023, it was not

occurring as frequently as deemed best practice by the provider. For example, from what the inspector observed staff appeared to have received two supervisions within the year instead of four.

Additionally, while staff were knowledgeable in many areas in order to support the residents, two staff spoken with were not familiar with a resident's epilepsy protocol in the case the resident required their rescue medication. One staff stated that the rescue medication was not required to be brought with the resident when they left the centre when in fact it was required to be brought every time the resident left their home. This would put the resident at risk of not receiving their rescue medication should they need it.

Furthermore, two staff members spoken with could not identify who the designated officer for safeguarding in the organisation was. Notwithstanding that, staff were clear to state that they would report any concerns to their manager as soon as possible.

Judgment: Not compliant

Regulation 23: Governance and management

There was a defined management structure in place. The provider had arrangements for an annual review of 2023 to be completed and it was being worked on at the time of this inspection and included family and resident consultation as required by the regulations.

In addition, there were arrangements for unannounced visits to review both apartments carried out on the provider's behalf on a six-monthly basis and the inspector had the opportunity to review the last two completed. It was found that similar issues with training, supervision and staffing were identified. As previously stated, the provider was actively recruiting to fill the staff vacancies. The person in charge had completed a document with actions for completion in order of priority for completion.

There were other local audits conducted in areas, for example vehicle checks, health and safety, finance, infection prevention and control (IPC), fire safety, and medication.

Periodic staff meetings were occurring in the centre and incidents were reviewed at these meetings and shared learning was promoted.

Judgment: Compliant

Quality and safety

Overall, the residents appeared happy and content in their home and in the presence of staff members. They were in receipt of individualised care and support. However, as previously stated, improvements were required in the general welfare and development for residents, individualised assessment and personal plan, protection against infection and fire precautions.

The inspector observed a notable improvement in one resident's access to the community since the last inspection. However, the provider had not always ensured that the other resident had access to opportunities for leisure and recreation out of their home and in their community. In addition, there was little evidence to suggest that much work had been done with the resident since the last inspection to encourage and support them to try new experiences.

Residents' needs were assessed on an annual basis, and reviewed in line with changing needs and circumstances. There were personal plans in place for any identified needs. Personal plans were reviewed at planned intervals for effectiveness. However, the assessment of need was limited in the scope of what areas it reviewed, for example it did not review a resident's independence skills. In addition, it was unclear where the time frame for administration of a rescue medication contained in one resident's epilepsy protocol came from. It was not evident if it was directed by the prescribing professional as there were no time frames specified in the signed guidance from them.

From a review of documentation, residents had access to a range of allied healthcare professionals in order to meet their identified healthcare and mental health needs. For example, they had access to a chiropodist and a general practitioner (G.P).

Restrictive practices were logged and periodically reviewed. It was very evident that efforts were being made to reduce restrictions in the centre to ensure the least restrictive were used for the shortest duration. Where residents presented with behaviour of concern, the provider had arrangements in place to ensure these residents were supported and received regular review.

There were arrangements in place to protect residents from the risk of abuse. For example, any potential safeguarding risk was investigated and where necessary, safeguarding measures were put in place.

The centre was being operated in a manner that promoted and respected the rights of residents. For example, the inspector observed a resident being afforded choice about what they had to eat and drink on the day of the inspection.

Residents were supported to communicate using their preferred methods. There were communication plans in place to support staff as to how best to communicate and understand what the resident maybe trying to communicate.

The inspector completed a walk-around of both apartments. They were observed to

have adequate space and were laid out to meet the needs of the residents.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. For example, there was a risk register in place along with a number of up-to-date risk assessments for identified risks. For example, risk of injury to others.

The inspector observed that there were arrangements in place to prevent or minimise the occurrence of a healthcare associated infection. However, more consideration was required to the storage of some PPE and the cleaning buckets for the centre in order to ensure they were clean and suitable for use. In addition, some areas required repair in order to ensure they could be properly cleaned.

There were fire safety management systems in place in the centre, which were kept under ongoing review. For example, servicing of the emergency lighting and the fire detection alarm. However, the inspector identified some issues with emergency lighting, fire containment doors and the fire detection alarm systems. The provider was responsive to these issues raised and provided written assurances subsequent to the inspection with regard to the majority of the identified issues.

Regulation 10: Communication

Residents were supported to communicate using their preferred methods. There were plans in place that utilised staff knowledge of the residents. In addition, centre management communicated to the inspector their intention to further develop and elaborate on these plans.

Residents had access to televisions in their apartments. They also had access to telephones and were supported to make phone calls including video calls in order to keep in contact their family members.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to maintain relationships with family. The inspector observed a noticeable improvement in the activities and length of time one resident was now able to spend out of their home participating in activities and outings. The resident appeared much happier in themselves and staff communicated that there was a marked improvement in the resident's presentation. However, it was communicated that the resident would benefit from more support staff hours in order to go out for longer periods or further away activities.

The inspector noted that significant improvement was required in the area of general welfare and development for the other resident. The last inspection for this

centre in August 2022, identified that the resident was limited in activities they appeared to want and be willing to participate in. It was communicated to the inspector at that time that staff, with the help of a behaviour support therapist, were attempting to slowly expand on their opportunities for new experiences, such as horse riding. There was also an aim to support the resident in coping with changes related with trying those new activities. However, on this inspection, the inspector observed limited evidence to suggest that much work had been completed in this area and the resident continued to only particulate in two specific activities out of their home.

In addition, as previously stated in this report, due to a lack of staffing the resident often did not have a second support staff available which meant they could not leave their home other than to go into their small garden which was not an inviting space for them. There had been occasions whereby the resident communicated that they would like to go out a do a particular activity they enjoyed; however, staff had to explain to them that they couldn't go out due to lack of a support staff.

Judgment: Not compliant

Regulation 17: Premises

The inspector observed the apartments had adequate space and they were laid out to meet the needs of the residents. The apartments were found to be clean and tidy.

The inspector observed some evidence of the apartments having either been recently redecorated or there were plans to redecorate other areas.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management arrangements ensured that risks were identified, monitored and periodically reviewed. These included, measures to manage infection control risks. Risks specific to individuals, such as travelling safely in the car, had also been assessed to inform care practices with associated risk management plans also in place.

There was an up-to-date organisational policy and a safety statement in place.

The inspector observed from a sample of the centre vehicles that it was taxed, insured and had an up-to-date national car test (NCT).

Judgment: Compliant

Regulation 27: Protection against infection

The apartments were observed to be clean and tidy. The inspector observed some evidence of residents being supported to receive recommended vaccines to help prevent certain infections. There were colour coded cleaning equipment for the apartments to help prevent cross contamination and reduce the likelihood of residents developing a healthcare associated infection.

However, as observed on the last inspection of this centre, more consideration was required with regard to the storage of some items in the centre, as some PPE was still being stored on a concrete floor of a hot press. The box was observed to be damp on the bottom and a malodour came from it when it was lifted.

In addition, the buckets used for cleaning the apartments were observed to be stored with pooled water and some debris in them which could lead to contamination.

Additionally, some areas required repair to ensure they could be properly cleaned. For example, the surface was peeling on the surround of one resident's cooker hob in apartment A and a radiator was slightly peeling and rusty.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were fire safety management systems in place. For example, each resident had a personal emergency evacuation plan (PEEP) in place to guide staff on evacuation support required. There was evidence of regular practice fire drills occurring which included minimum staffing levels.

The inspector observed improvements in some areas of fire precautions since the last inspection. For example, final exit doors were now fitted with thumb turn locks which allowed for timely access to outside of the property in the event of an emergency. In addition, one resident's hall door was no longer kept locked which promoted more timely egress from the building and no reliance on keys for unlocking doors.

However, the inspector observed that there was no emergency lighting at the front door to one apartment. The inspector observed the area outside of the centre was very dark at night and while there was an external light at the property. The light was not a senor light and therefore there was a reliance on staff needing to switch it on in the event of an emergency and it was not evident if it would work in the event

of a power outage.

Fire containment doors in apartment B would not close by themselves as the resident had broken the self-closing devices. The provider had contacted the company responsible for the repair of the devices prior to this inspection and they had visited the centre to assess the doors. The provider had been awaiting the return of the company to fix the doors once the ordered parts came in.

While the majority of servicing records for emergency lighting and the fire detection alarm were available on the day of the inspection, one required quarterly servicing was not evident. The fire extinguishers certification had recently expired at the start of the month; however, no date was provided for the company responsible for the servicing to call out to service the extinguishers.

Furthermore, while it was evidenced that the attic was covered by the fire detection system, the inspector raised a query with the provider as to the coverage of the fire detection alarm system based on information provided at the time of the inspection. This was in order to ensure that it provided adequate coverage for the centre.

The provider submitted written assurances subsequent to this inspection that all fire containment doors were now closing and the self-closing devices fixed. In addition, that emergency lighting would be installed externally on the property and that the level of coverage for the alarm detection system was to be increased to bring it up to a higher standard alarm system by 06/03/2024.

The provider was unable to establish if two doors were fire containment doors in apartment B and had committed in writing to having them replaced by no later than 19/08/2024 or sooner if possible.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had an annual review of their goals they were working on for the year ahead and their family were invited to attend. Some goals were already achieved by the time of this inspection and some were on-going. For example, one resident was supported to attend a local park run each week whereby they walked the set route. Another goal was to attend a particular music festival which they did.

Each resident had an assessment of need completed; however, it was not a comprehensive assessment of the residents' health, personal and social care needs and was found to be limited in its scope. The assessment presented to the inspector only focused around the residents' social care needs. There was a separate financial assessment completed. The inspector did not see evidence of other areas assessed, for example a person's independence in or out of their home.

There were personal plans in place for residents as required, for example eating,

drinking and swallowing plans. However, one epilepsy care plan and protocol, completed by staff members, was overdue for review. In addition, in the protocol, it was not evident where the direction for the time frame for administration of emergency epilepsy medication came from. There was no evidence it was directed by the prescribing professional as the separate documentation signed by them had not described any specific time frames of when to administer this medication.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' identified healthcare and mental health needs were monitored within the centre on an ongoing basis with the residents having access to appropriate healthcare professionals as required. For example, a dentist, a G.P and hospital appointments.

Since the last inspection, one resident had recently received an appointment for a required psychiatrist review.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had access to a behaviour therapist as required, in order to support them to manage their behaviour positively. There were positive behaviour support plans in place for residents as required, which clearly guided staff as to how best to support them and they were reviewed by a behaviour therapist.

The behaviour therapist had attended the team meetings for one of the residents for the last number of months. This was in order to support staff and in turn support the resident with the reduction of some restrictive practices that had been used in one apartment. In addition, the behaviour therapist reviewed any behavioural incidents for the residents.

While there were restrictive practices in place they were deemed necessary for residents' safety and they were subject to periodic review. For example, some internal and external doors were kept locked. The centre had completed a self-assessment questionnaire in order to ascertain if they were operating within best practice when it came to restrictive practices. The centre had made significant improvements in the reducing or removal of restrictive practices that impacted on the residents. In particular, one resident now had much increased access to different areas of their home.

For example, the kitchen was previously deemed unsafe for them to be present in

due to some behaviours they displayed that challenged. With the support from the behaviour therapist, staff members had slowly worked to reduce the kitchen door being locked. The resident now had unlimited access to enter their kitchen space and now enjoyed their meals at their kitchen table. This was a significant step forward for the resident and greatly improved their quality of life and their freedom of movement within their home.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place. Residents' finances were safeguarded by the completion of financial audits every two months and finances were counted twice daily by staff members. There were intimate care plans in place to guide staff on how best to support residents.

Staff had access to appropriate training and staff spoken with were aware of the procedures to follow in the event of an incident of abuse occurring in the centre. Any potential safeguarding risks were found to be investigated, reported to the relevant statutory agency and safeguarding measures put in place.

Judgment: Compliant

Regulation 9: Residents' rights

The individual choices and preference of the residents were promoted and supported by staff. Choice was afforded in areas of daily living from activities to meal choices.

The inspector observed staff members responsive to residents' requests and communicated needs. For example, when a resident asked for a specific drink and it wasn't available in the apartment they went to the shop to buy it. Staff members were observed to respond in a timely manner to the residents. They were also observed to speak to residents in a calm and respectful manner.

As previously stated, a reduction in restrictive practices was also contributing to one resident having more choice and control in their daily life. For example, the resident now had access to additional areas of their home which promoted their freedom of movement. They also now had free access to a some food choices at different times of each day within their kitchen. The remainder of their food was stored in an alternative locked part of their home to promote their safety.

The inspector saw evidence of staff completing a desensitisation programme with

one resident to support them around getting blood tests.

There were weekly residents' meetings occurring in the centre and there was easy-to-read information available to help keep residents informed and support their understanding.

As previous mentioned, one resident's right to leave their home was being impacted by a lack of a second support staff. This is being actioned under Regulation 13: General welfare and development and Regulation 15: Staffing.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Delvin Centre 4 OSV-0007483

Inspection ID: MON-0039207

Date of inspection: 13/02/2024

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 has run a recent recruitment campaign and will interview staff on 22.03.2024. • Support shifts are currently being covered by familiar relief and agency staff, which suits the resident, PIC oversees inductions. • PIC has reviewed rosters across both apartments to look at utilising staff resources to maximise support for both residents- staff familiar to both residents will work across both locations to ensure support is delivered to both residents across the day.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • PIC has undertaken a full review of all staff training needs across the designated centre and staff with training gaps have been sent the required training links with a timeline for training completion. • Positive Behaviour Support training has been scheduled across 3 dates in April and May 2024 – all training will be completed by 14.05.2024. • PIC has started a Staff Supervision & Support schedule with the staff team in Delvin Centre 4. PIC has created a Supervision and Support Schedule for all staff for 2024 and shared PPIM. • All staff have been asked to review the resident's Epilepsy Management Plan, this will also be fully reviewed at the staff team meeting on 15.03.2024. • Staff members unable to identify rescue medication have been forwarded for full safe administration of medication training. • Staff unable to identify DO have been directed to undertake safeguarding training again.	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development:	

• PIC has run a recent recruitment campaign and will interview staff on 22.03.2024.
• Support shifts are currently being covered by familiar relief and agency staff, which suits the resident.
• PIC has reviewed rosters across both apartments to look at utilising staff resources to maximise support for both residents- staff familiar to both residents will work across both locations to ensure supports are delivered to both residents across the day.
• PIC monitors the weekly activity schedule for both residents.
• PIC and Keyworker are scheduled to meet on 20.04.2024 to begin development of a community map for residents to explore new activities/opportunities in his local community, this will then be written up in residents goal planner and reviewed accordingly.
• PIC has requested power washing and tidying up of the back garden area and put planters and decorations over the springtime.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• All PPE is now stored in large plastic sealed containers in their original packaging.
• Mop Buckets and mops are stored in outdoor storage area as per Cleaning & Disinfection Policy.
• A new cooker is on order for apartment A, awaiting delivery.
• Radiator repairs on maintenance request for Apartment A – sanding and repainting

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All fire doors now have self-closures and are working effectively and in line with fire regulations.
• Gaps between fire doors and door frames adjusted in line with fire compliance.
• Smoke seals and Intumescent seals have been installed.
• Emergency lighting in the hallway in Apartment B installed.
• Emergency sensor lighting outside front and rear door exits installed.

• The fire alarm system is L3 and there is a new additional fire panel in Apartment B office which meets compliance for community dwelling.
• The fire system covers attic space and there is separate test switch.
• All fire extinguishers have been serviced on 29.02.2024.
• Fire Containment doors to be replaced in Apartment B no later 19.08.2024.
• All servicing records for emergency lighting, the fire detection alarm and all fire extinguishers are now available in the designated 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:
• PIC has sourced a more comprehensive healthcare assessment of need and is currently completing with support from a nursing colleague, to be completed by 20.03.2024.
• The Epilepsy care plan and PRN protocol has been updated by GP and signed by PIC.

• PIC will conduct a full review of residents' assessment of needs to incorporate comprehensive assessment of the residents' health, personal and social care needs. This will be reviewed on an annual basis.

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)(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	24/05/2024
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	24/05/2024
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	24/05/2024

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/05/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2024
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	30/04/2024
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape,	Substantially Compliant	Yellow	07/03/2024

	including emergency lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	19/08/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	05/04/2024
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	20/03/2024