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:	Beaufort Campus Units Area 2 - St. John of God Kerry Services
Name of provider:	St John of God Community Services CLG
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	25 May 2023
Centre ID:	OSV-0002905
Fieldwork ID:	MON-0034786

About the designated centre

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

The service was based on a large campus in proximity to a rural village. The service provided residential care for up to 29 residents who had moderate or severe intellectual disability. Some residents had a dual diagnosis and significant medical conditions. Residents were male and female and three of the residents availed of shared care. Many of the residents had lived in the designated centre since they were young children. Accommodation was in five separate houses or units and an apartment. Between three and six residents resided in each of the five houses. All accommodation was at ground floor level. The campus grounds were generally well maintained. The service provided was a medical model of care and the staff team comprised of nurses and care assistants. The designated centre was closed to future external admissions.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 25 May 2023	09:15hrs to 18:00hrs	Elaine McKeown	Lead
Thursday 25 May 2023	09:15hrs to 18:00hrs	Kerrie O'Halloran	Support

What residents told us and what inspectors observed

This was an unannounced inspection to monitor the provider's compliance with the regulations and to follow up on the provider's progress with actions identified from the previous inspection completed in November 2021. In addition, ensuring residents were being supported to have a good quality of life in a safe environment while being supported as per their assessed needs.

The designated centre was based on a campus setting and was made up of five bungalow type houses, one of which had an adjoining individualised apartment, and two of which were linked by a connecting corridor and door. All five bungalows and apartment were located in close proximity to each other. This centre is registered for a maximum of 29 residents and at the time of this inspection was providing residential support to 26 residents.

Both inspectors visited all of the buildings that are part of this designated centre during the inspection. In addition, the inspectors reviewed documentation relating to the centre, spoke and met residents, staff and the management team during the inspection. In total 21 residents were met by one or more of the inspectors during the day at times that suited the residents daily routines. A number of residents were attending their day services or community activities such as a local community men's shed group when the inspectors visited.

Shortly after the inspection commenced inspectors visited one bungalow where six residents were living. Residents were observed to be ready for their day. Some residents had already left for their day service. One resident spoke to the inspectors about activities they like to do, this included going to the gym, listening to their favourite music, watching mass and going to concerts and shows in a nearby town. The resident had recently gone for a haircut supported by a family member which they were very pleased about. Staff were supporting a number of residents to watch mass which was being live streamed. Another resident was observed relaxing in the conservatory area with some music.

All residents had their own bedroom in this designated centre since February 2022. The inspectors were informed of the transition of a number of residents to houses within this designated centre and to another designated centre. Staff spoke of one resident expressing their preference to live on their own in the apartment which was achieved during 2022. Another resident completed a short transition to one of the other houses in this designated centre after visiting the location. They expressed their preference to remain in the new location and this was supported by the staff team.

The inspectors were informed there was a number of residents being supported to attend activities during the day as part of their "meaningful day". Support was also available from the social and recreational team on the campus to facilitate campus based and community activities. Two residents were gone to a local park with plans

to visit a café before inspectors called to their home. In addition, this team also provided additional supports for residents to plan activities, day trips and overnight trips to various locations around Ireland.

All staff spoken to throughout the inspection demonstrated their awareness of their roles and responsibilities. They were familiar with the assessed needs of the residents for whom they were providing support. In addition, the inspectors were provided with examples of preferred activities and routines of the residents living in this designated centre. Staff were observed to interact with residents in a kind and respectful way. There was a positive atmosphere in the centre, with residents and staff observed going for walks, listening to music, supporting activities such as, painting, table top craft work and going out in the community to do some shopping. At the time of this inspection, over half of the staff team had completed training in human rights as requested by the provider. The inspectors were informed all of the staff team were expected to have completed the required training on-line by the end of June 2023.

The inspectors observed staff communicating with the residents consistent with their preferences. All of the bungalows visited had a weekly activity schedule displayed in picture format for each resident, along with a menu plan. Residents who engaged with inspectors gave positive feedback about their homes and lives in the designated centre.

All of the buildings were observed to be well ventilated on the day due to the warm weather, windows and doors were observed to be open. A number of residents met the inspectors outside. One resident was sitting under the protection of an awning from the sunshine. Another resident proudly showed an inspector their tricycle as they went for a cycle around the grounds with a staff member in the afternoon.

Staff in one of the houses explained that a number of the residents living there had been unwell in the days prior to this inspection so their routine had been changed to reflect their energy levels. This included listening to music in the conservatory/sun room or completing table top activities instead of attending their day service which staff were of the opinion would have been too tiring for them on the day of the inspection.

Inspectors observed residents in a number of the houses being supported to have their mid-day meals in an un-rushed manner. Staff were observed to sit close to the residents they were supporting and engage with each resident.

The provider was aware of a number of issues relating to premises and had a maintenance schedule and de-congregation plan in place. Overall the premises and the maintenance of the centres was generally good. However, there was some variance in the premises provided for residents to live in. For example, the flooring in two of the bungalows was seen to have large gaps in the flooring, plastering was required around one of the external doors of one bungalow and storage in some of the houses required review.

However, the inspectors were not assured effective fire safety measures were in place when visiting one of the houses. A fire door was observed held back with a

metal hook which was attached to a wall in a kitchen area. This would not allow the fire door to create an effective containment of the kitchen if the fire alarm was activated. The hook was immediately released. The inspectors were informed during the feedback meeting that the hook had been removed. This will be further discussed in the quality and safety section of this report

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

Capacity and capability

Overall, the inspectors found that there was a governance and management structure with systems in place which aimed to promote a safe and person-centred service in this designated centre.

The person in charge worked full-time and their remit was over this designated centre. The person in charge was suitably qualified and experienced. They were supported in their role by three unit heads. Throughout the inspection the person in charge and the unit heads on duty demonstrated their awareness of their roles, responsibilities and the assessed needs of the residents in the designated centre. Systems were in place to monitor the quality and safety of the service delivered to residents. The person in charge explained to the inspectors about the management systems they had in place to ensure that they were able to maintain full oversight of the large designated centre. This included delegation of duties to the unit heads in the houses.

The person in charge oversaw the staff team that was provided to support the residents of this centre. In accordance with the regulations the staffing arrangements should be consistent with the needs of the residents and the centre's statement of purpose. The statement of purpose for the centre specifically indicated the staffing in place in the centre. One inspector reviewed some of the staffing rosters for 2023. There was an actual and planned roster in place. Flexibility of staff resources was evident to support the individual needs of residents. For example, an additional staff resource was in place in one of the houses in the evening time between 18:00 hrs and 20:30 hours. The inspectors were informed that there were a number of staff vacancies on the day of the inspection. The provider was actively recruiting to fill these positions. The designated centre was supported with relief staff and agency staff. These staff were seen to be consistently utilised by the centre and were familiar with the needs of the resident they were supporting.

The provider had ensured an annual review and internal provider–led six monthly audits had been completed as required by the regulations. Actions had been

identified and updated information on the progress was documented in the six monthly audits that took place in August 2022 and February 2023. The annual review had been completed in March 2023 reflective of the designated centre during 2022. Part of this report was also presented in an easy–to-read format. Views of the residents and family representatives were also included in the document, which reflected a number of positive outcomes for residents. However, the auditors did identify an adverse impact on some residents relating to their living environments. This will be further discussed in the quality and safety section of the report.

The inspector found that the provider had systems in place for a complaints process. An easy-to-read complaints procedure was available for residents and a flow chart was on display for residents. The person in charge outlined the process including if needed access for residents to an appeals process. Some residents spoken too during the inspection indicated a staff member they would speak to if they wished to make a complaint. Residents meetings held in the centre informed residents of their right to make a complaint. Staff spoken to also demonstrated their knowledge of the complaints process in place and how they would support a resident or family member to make a complaint. There were no open complaints on the day of the inspection.

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to work full time and they held the necessary skills and qualifications to carry out their role.

Judgment: Compliant

Regulation 15: Staffing

The inspectors found that on the day of the inspection there were sufficient numbers of staff on duty to ensure the residents' assessed needs could be met. The person in charge and unit heads had reviewed the rosters and there were actual and planned rosters maintained. Staffing was being provided in line with the provider statement of purpose. While on the day of the inspection a number of positions remained vacant (6.5WTE), the provider was actively recruiting for these roles. The provider had relief staff in place and the use of regular agency staff to cover the vacancies.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of the training records, it was evident that the staff team had access to appropriate training, including refresher training.

The provider expected all staff in the designated centre to have completed training in human rights by the end of June 2023. Over 55% of staff team had completed this training at the time of this inspection.

The provider identified and scheduled upcoming refresher training for staff for management of actual and potential aggression. However, some staff were overdue training in fire safety. Staff supervisions had taken place during 2022 and were scheduled for 2023.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had ensured the designated centre was resourced to ensure the effective delivery of care and support to residents. The registered provider had also completed an annual review and internal provider led audits with actions identified. Some actions had been completed or progress documented. However, the review of personal goals for some residents as recommended in the Feburary 2023 internal audit had not been completed. This will be actioned under Regulation 5: Individual assessment and personal plan.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. It reflected the services and facilities provided at the centre and contained all the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints procedure in place with an easy-to-read format available for residents to refer to if required. The complaints flow chart was on display. Residents were supported to make complaints if desired, actions and resident satisfaction with the outcome were recorded. Staff were familiar with the complaints process. An appeals process was also available to residents.

Judgment: Compliant

Quality and safety

Overall, a dedicated staff team were providing a good standard of care and support to provide a person centred service where the individuality of the resident was respected. The provider had made progress in addressing actions identified in the previous HIQA inspection completed in November 2021. For example, all residents were being supported in single bedrooms, new furnishings were evident in some areas and the successful transition of some residents had taken place.

However, not all areas of the designated centre were observed to be in a good state of repair, some residents goals had not been progressed or new goals identified if goals had been achieved. The storage of personal items in some areas including bedrooms of the designated centre was not sufficient. As previously mentioned in this report the annual review completed in March 2023 had identified issues pertaining to residents rights. The bedroom space for one resident was too small and the environment for two residents was described as being noisy and busy. The recommendations from the auditors was that both of the residents would benefit from a quieter environment.

As previously mentioned in this report a fire door was observed to be held open for a short period of time when inspectors were visiting one of the houses in this designated centre. This was immediately addressed. However, the provider's own fire safety precautions reviewed by one of the inspectors advise staff in section three that "no fire door is to be wedged or held open". A staff office was also observed to have a hook on the wall near a door opening in another building. The inspectors were informed that the provider had completed a fire safety audit with actions identified to be addressed. This report was not reviewed during this inspection. However, inspectors outlined to the management team during the feedback meeting, the importance of ensuring all staff were aware of the provider's own fire safety precautions and adhered to these consistently to ensure effective fire safety measures were in place.

All residents had personal emergency evacuation plans (PEEPs) in place which were subject to regular review. Information was contained in these documents to assist

staff with the effective evacuation of residents. For example, one resident may be drowsy due to medications taken at night if they needed to be evacuated and required staff supervision. Another resident could be offered their preferred hot drink, other PEEPs reviewed also listed options for staff to encourage the participation of residents in fire drills and evacuations. The inspectors were informed by staff due to the changing assessed needs of the residents in one house, two ski sheets were available for staff to use in the event of a full evacuation being required. The staff explained how they practiced weekly among the staff team to ensure the effective use of these fire safety aids. The staff team were required to practice on a nominated day each week to ensure the whole staff team participated frequently. However, on the specific recording document shown to one inspector this had not been documented as being completed in the weeks prior to this inspection.

The inspectors reviewed a sample of the resident individual personal plans in place. Such plans are required by the regulations and are intended to provide guidance for staff in meeting the assessed needs of the residents. Residents' were supported to have a personal plan in place with input from family representatives where possible. Each resident was supported by a key–worker. Residents were actively being supported to engage in activities both on the campus and in the wider community settings regularly. The input and resources of the social and recreational team had a positive impact for the residents also. However, there was some variance in the goals documented for residents in the personal plans reviewed by the inspectors during this inspection. For example, one resident was being effectively supported with a stepped approach to engage in community activities. This commenced with staff creating a seating arrangement in the designated centre which imitated the layout of the transport vehicle. The progress of supporting this resident to attain their goal was well documented and progressing. However, other residents had goals in place that had been achieved and were part of their meaningful day for a number of months at the time of this inspection. The auditors of the annual review had also recommended new goals should be considered if current goals had been achieved while considering the will and preference of the resident.

While there was evidence of maintenance and upgrading of furniture in some areas of the designated centre, this was not consistent throughout all of the buildings that were part of this designated centre. Some areas required painting both internally and externally. As previously mentioned all of the residents were being supported in single occupancy rooms. However, the space available to one resident in their bedroom was limited. Personal items were observed to be stored on the floor, which adversely impacted the ability of staff to effectively clean the floor space. There were a number of other bedrooms that were observed to have personal possessions stored directly on the floor space during the inspection. The use of floor space in a storage room also adversely impacted the effective cleaning of that area. Gaps were also evident in the flooring throughout two of the houses and there was evidence of wear and tear on some kitchen units.

The staff team outlined the positive impact the reduction in the number of residents in the houses had within the designated centre. This included increased access for the current residents to meaningful activities daily. The staff team in each house

was mindful of individual preferences and supported residents to engage in activities away from the designated centre whenever possible. This supported other residents who preferred to spend time in their home to enjoy a quieter space. However, it had been identified that two residents would benefit from living in a quieter environment. The inspectors acknowledge that the provider is continuing to progress with a de-congregation plan and providing staffing resources to reduce the impact of the unsuitable busy environment for the residents. At the time of this inspection both residents were remaining in their current homes.

The staff team were supported by the multidisciplinary team to ensure the assessed needs of the residents were being met. This included the effective use of scatter charts to monitor individual residents' behaviours of concern. Information gathered in these charts were reviewed by the team and assisted with reducing some restrictions where possible. For example, the duration of water tap restrictions in one house. Another resident's vocalisations had decreased due to a change in the daily routine which included a structured day service and weekly input from the social and recreational team. Another resident was being supported daily to independently make themselves a hot drink. The inspectors were informed of the routine and support plan in place around this activity which was having a positive impact on the life of the resident. Another resident was supported with healthy meal planning and preparation in the evenings in their home. Overall, the inspectors found most of the residents were being supported to live in a homely environment, with minimal restrictions and adequate resources to ensure a good quality of life.

Regulation 10: Communication

The provider had ensured all the residents were supported and assisted to communicate in accordance with their needs and wishes. Each resident had a communication passport. Staff were familiar with particular vocalisations and words that residents used regularly to communicate. Staff were aware of the importance to ensure consistent responses were provided to residents at all times.

In addition, residents were supported to use technology to maintain relationships and contact with family representatives. Assistive technology was also provided to one resident so they could independently access their radio.

Judgment: Compliant

Regulation 12: Personal possessions

Not all residents had adequate space to store their personal property and possessions. Items were being stored directly on floor surfaces in a number of

bedrooms.

Judgment: Not compliant

Regulation 13: General welfare and development

The provider had ensured residents were supported in –line with their expressed wishes and known preferences to participate in a variety of activities. These included attending day services, swimming pool and gym facilities on the campus. In addition to community activities such as attending art classes, social groups such as the men's shed and social farming. Residents were also supported to attend concerts and social events.

Routines were scheduled to reflect individual residents. For example, staff supported one resident to engage in activities later in the morning which had a more beneficial outcome for the resident. The input of the social and recreational team also provided additional scope for residents to participate in meaningful activities regularly.

Judgment: Compliant

Regulation 17: Premises

Not all of the buildings within the designated centre were maintained to a good state of repair. While some areas did evidence upgrading had occurred this was not consistent throughout the designated centre at the time of this inspection.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had ensured that systems were in place in the designated centre for the assessment, management and ongoing review of risk. The person in charge maintained a risk register for the designated centre, and each resident had individual risks identified. These were regularly reviewed by the person in charge.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had procedures in place to ensure the ongoing safety of the residents. Dedicated household staff were employed by the provider to assist with the cleaning duties in the designated centre. There was evidence of regular cleaning in areas, in –line with the provider's protocols. For example, the use of colour coded cleaning equipment was being used appropriately.

However, the impact of inadequate storage in some areas and damage to surfaces including floors and kitchen units adversely impacted on the effectiveness of the cleaning routines being carried out.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had ensured fire safety management systems were in place which included making adequate arrangements for the maintenance of all fire equipment, reviewing fire precautions and testing fire equipment.

However, the practice of preventing fire doors from closing which was not in-line with the provider's own fire safety precautions did not provide assurance that effective fire safety measures were consistently adhered to. The inspectors acknowledge that they were informed by the management team that the metal hook in the kitchen of one house had been removed before the end of the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that comprehensive assessments had been completed and were subject to regular review to support the assessed needs of the residents. The residents and where possible family representatives were included in the process of personal planning and identifying meaningful goals. Residents were supported by key workers who were familiar with their assessed needs.

However, variance in the review of personal plans, in particular the progression of some residents personal goals was evident during the inspection

Judgment: Substantially compliant

Regulation 6: Health care

The provider had ensured the residents were supported to access allied healthcare professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff demonstrated their knowledge and awareness of the behavioural supports required by the residents during the inspection.

Positive behaviour support plans were subject to regular review. Information contained within the plans provided clear guidance for staff to support the individual. For example, one resident responded well to familiar staff during periods of heightened anxiety.

There were a number of restrictive practices in place in the designated centre. These were subject to regular review. Restrictive practices were in place for the shortest duration and documented. For example, a kitchen door was locked for approximately 30 minutes each morning in one house while staff supported residents with their assessed needs. This was required in the event of one resident getting up independently during that time and accessing the kitchen. Due to increased assistance being required by some residents due to illness the door had to remain locked for one hour on a particular day. Staff were aware of the rationale of the extended period and the restriction was removed once a staff member was available to support the resident should they get up and wish to enter the kitchen area. The resident had remained in bed during this period and was reported to have not been adversely affected by the duration of the door being locked.

Judgment: Compliant

Regulation 8: Protection

The provider had ensured all staff had attended training in safeguarding. Staff were knowledgeable of an active safeguarding plan in place at the time of this inspection. However, another safeguarding plan remained active with ongoing monitoring for a

resident since September 2021. This was discussed during the inspection with the person in charge who outlined as the residents remained living together the safeguarding plan was required to be monitored. The inspectors were informed this was the direction given to the provider from the Health Services Executive safeguarding team.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had ensured improvements had been made supporting the privacy and dignity of residents with all residents having a single occupancy bedrooms since February 2022. A number of residents had successfully transitioned to the community or internally within the designated centre which had a positive impact on their lives.

The provider was also supporting the residents and staff team with increased awareness and training in the area of assisted decision making. The support of a transforming lives co-ordinator was also a positive resource for the designated centre and the residents.

Residents were supported to access the local community and integrate into social groups and classes.

However, two residents were living in noisy and busy environments as per the auditors findings in the recent annual review. While the staffing resources were available to support residents to engage in meaningful activities and reduce the noise in the residents home, the environment was not deemed to be suitable for 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially 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	Substantially compliant

Compliance Plan for Beaufort Campus Units Area 2 - St. John of God Kerry Services OSV-0002905

Inspection ID: MON-0034786

Date of inspection: 25/05/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - A number of staff have completed fire safety training since the inspection and all remaining staff members will be scheduled to attend fire safety training by 30th Sept 2023 (training provided by APEX Fire). Time frame: 30 Sept 2023	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: -In consultation with the individual and their keyworker additional storage will be provided to a number of residents bedrooms in the form of seated storage units. In another resident's bedroom there will be storage fitted under the sink. These works have also been included in the maintenance schedule. Time frame: 30 Dec 2023 -A vacant multipurpose room in one location will be cleared and will be utilized for storage purpose should residents wish to store personal possessions there. Time frame: 30 July 2023	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
-Two locations in the DC have been approved for kitchens to be upgraded. The Registered Provider is presently awaiting on the availability of procured contractors to carry out this work. Time frame: 30 Dec 2023

-Communal areas and bedroom flooring to be upgraded. These works have also been included in the maintenance schedule. Time frame: 30 Dec 2023

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
-In consultation with the individual and their keyworker additional storage will be provided to a number of residents bedrooms in the form of seated storage units. In another resident's bedroom there will be storage fitted under the sink. These works have also been included in the maintenance schedule. Time frame: 30 Dec 2023

-Two locations in the DC have been approved for kitchens to be upgraded. The Registered Provider is presently awaiting on the availability of procured contractors to carry out this work. Time frame: 30 Dec 2023

- Communal areas and bedroom flooring to be upgraded. These works have also been included in the maintenance schedule. Time frame: 30 Dec 2023

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
-The fire door that was observed to be held open on the day of the audit was immediately addressed. The hook was immediately removed and an automatic door closer has been installed and linked with the fire detection system. A review of all other fire doors took place by the Health and Safety Co-ordinator and no other hook systems were identified. Time frame: Completed

-Communication on the fire safety precautions will be issued to all staff; reinforcing that

"no fire door is to be wedged or held open" and the importance of adhering to fire precaution measures. Time frame: 07 July 2023

-Health and Safety coordinator to conduct unannounced inspection of the DC to ensure ongoing compliance with fire precaution measures. Time frame: 30 Oct 2023

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:
The Annual Planning meeting document which includes the residents' goals and quarterly reviews has been updated to include a prompt that an additional goal may be required for residents if existing goals have been achieved. Completed

-The project coordinator has put in place a tracker system so that the annual planning meetings can be reviewed to ensure quarterly reviews are taking place for individuals. Completed

-Quarterly reviews of the Annual Planning meeting will be monitored by the PIC to ensure same has taken place. Time frame: 30 Dec 2023

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Discovery work has been carried out with a number of individuals from the DC and their will and preference has identified a property in Killarney town as a suitable residence for their needs and wishes. Timeframe: Completed

Transition plans are currently being developed with individuals in conjunction with family members. The residents have also been provided with the opportunity to view the property being purchased. The residents also expressed great satisfaction with this property including its location. Timeframe: ongoing

Purchase of a property in Killarney town currently being progressed.
Timeframe: Subject to Sale being completed

Staff team to be recruited and inducted into the needs, wishes and supports of the residents. Timeframe: Subject to Sale being completed

Internal works to the property identified to bring same into compliance with fire regulations and Occupational Therapy modifications as identified in the occupational therapy report. Timeframe: Subject to Sale being completed

The organization will then submit an application to HIQA for registration for this property. Timeframe: Subject to Sale being completed

Overall planned timeframe: 30 June 2024

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 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.	Not Compliant	Orange	30/12/2023
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.	Substantially Compliant	Yellow	30/09/2023
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	Substantially Compliant	Yellow	30/12/2023

	internally.			
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	30/12/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/10/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/12/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy	Substantially Compliant	Yellow	30/06/2024

	and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			