



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

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| Name of designated centre: | Caislean |
| Name of provider: | Brothers of Charity Services Ireland CLG |
| Address of centre: | Clare |
| Type of inspection: | Announced |
| Date of inspection: | 25 January 2022 |
| Centre ID: | OSV-0005361 |
| Fieldwork ID: | MON-0027384 |

About the designated centre

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

Caislean is a centre run by Brothers of Charity Services Ireland. A full-time residential service is provided for a maximum of two residents, both of whom must be over the age of 18 years. The centre is located in close proximity to the services and amenities offered by the busy town. The house is a two-storey premises where residents have access to their own bedroom, some en-suite facilities, shared bathrooms, communal areas and a garden. The model of support is social and staff are on duty both day and night to support the residents. Day to day management and oversight of the service is delegated to the person in charge supported by a social care worker.

The following information outlines some additional data on this centre.

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| Number of residents on the date of inspection: | 2 |
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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 25 January 2022 | 09:45hrs to 16:30hrs | Mary Moore | Lead |

What residents told us and what inspectors observed

The provider had submitted an application seeking renewal of the registration of this centre. Further to that application this inspection was undertaken to assess the provider's level of compliance with the regulations. This included following up on the findings of the last HIQA (Health Information and Quality Authority) inspection. Much improvement was noted. For example, the provider had improved both staffing levels and consistency of staffing levels across the week. There was evidence of improved, structured, consistent oversight and good alignment of in-house oversight and provider level oversight. However, on the day of inspection the inspector found a lack of vigilance and a lack of effectiveness in relation to controls that were in place to manage a risk to resident safety.

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. There was sufficient space for the inspector to be safely based in the house and to have the opportunity to interact with residents, meet with staff and observe the support provided.

Two residents live in this centre on a full-time basis. Both residents communicate by means other than verbal communication such as manual signing, gesture and the purposeful use of words. One resident utilises communication applications on their personal tablet. The inspector saw that these communication differences did not present any challenges for residents or staff. Staff and residents were seen to clearly understand each other as routines were discussed and agreed and residents expressed their choices and preferences. Staff offering choice was fundamental to the support observed with residents indicating by gesture their preferred option. For example, where they wished to go and what they wanted to do. While both residents may not have provided explicit detailed feedback on what life was like for them in the centre they indicated by gesture to the inspector that they were happy and having a good day.

As this inspection was announced staff had supported residents to complete the HIQA questionnaire. Staff recorded how residents had communicated their response to questions asked. For example, residents were noted to nod their head or sign yes when asked if they felt safe in the centre. A resident retrieved their wallet and showed it to staff when asked if they had access to their personal monies. One resident had said they would like to have an air-fryer appliance in the house. The inspector saw that this had been purchased.

The inspector did not meet with any resident representative but saw they were invited to provide feedback each year that was used to inform the provider's annual review of the service. The most recent feedback on file was very positive. In addition, the person in charge confirmed there was regular contact with representatives.

Both residents had continued access to home and family. Residents did share a car for the purposes of accessing the community and other amenities. Staff spoken with said this was not an issue as they had access to other service vehicles as needed. There was a suite of risk assessments in place and staff described reasonable controls to ensure visits and community access was safe in the context of COVID-19.

As discussed at the time of the last HIQA inspection national restrictions had brought challenges and anxieties for residents as services and amenities they enjoyed had closed. The inspector saw that residents were reengaging with their community and with life in general. Both residents spent most of the day out and about in the community or attending external therapeutic programmes. The enhanced staffing levels effectively meant each resident received an individualised service each day. One resident showed the inspector their visual personal plan and pointed out what they most enjoyed doing. This included their new interest and participation in gardening and video calls with friends.

Both residents in the context of their disability were limited in their ability to protect themselves from the risk of COVID-19. The inspector saw that with time and support from staff residents developed an understanding and tolerance for using a face mask or a protective visor in certain situations. Staff carried hand sanitiser with them when out in the community and supported residents to undertake hand-hygiene using hand over hand assistance. In general, there was evidence of infection prevention and control vigilance. For example, inspector well-being was ascertained on arrival, all staff were aware of updated national guidance and were seen to wear the higher specification face mask recommended for all resident care activities. However, some improvement was needed. For example, explicit centre specific procedures were needed for the care and maintenance of reusable clinical equipment.

Overall, there was evidence of improved systems for identifying, assessing and responding to risks. Good oversight was maintained of incidents and any changes in resident needs. However, observations on the day of inspection demonstrated both a lack of vigilance and possible ineffectiveness of controls in place in response to an identified particular risk to resident safety. This was brought to the immediate attention of the person in charge by the inspector who was requested to take action to address supervision, vigilance and effectiveness of the existing controls.

In summary, this was a person centred service where residents received support and care individualised to their needs, abilities and choices. There was evidence of improved governance and oversight and improved compliance with regulatory requirements. However, some improvement was needed in the procedures that underpinned infection prevention and control practice, in the procedures for undertaking simulated evacuation drills and in the management of identified risks to ensure residents were at all times safe.

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 delivered.

Capacity and capability

As stated in the opening section of this report there was evidence of improved governance and oversight that was focused on each resident and the quality and safety of the service they received. The provider had completed the actions it said it would take further to the findings of the last HIQA inspection of this service in October 2020. The inspector found good integration between systems of oversight and review, better use of data that was collated and evidence that the governance structure was operated as intended by the provider.

The person in charge had other areas of responsibility including two other designated centres. The person in charge described to the inspector how they managed this and endeavoured to be present in the centre two days each week. The person in charge was supported in the management and oversight of the service by a social care worker. It was evident that the person in charge was well informed of matters arising in the centre and had formal systems of management and oversight. For example, the person in charge reviewed the management of incidents maintained oversight of practice such as medicines management including the use of any as needed medicines. Findings from reviews resulted in actions to improve the service such as referral to the appropriate clinicians, review of prescribed medicines and regular staff meetings for the purposes of discussion with and feedback to staff. Oversight was maintained by senior management of the findings of in-house monitoring systems.

In addition, the person in charge had completed the annual review and the provider was completing on schedule the six-monthly reviews of the quality and safety of the service. Lines of enquiry were robust and each review followed up on the action plan that had issued from the previous review to ensure they were satisfactorily completed. Reports seen stated that they were. In addition, there was an overall service improvement plan that collated all actions that issued from reviews. The progress of the plan was monitored by the local and senior management teams. However, better oversight would have prevented the failings identified by this inspection in risk management and fire safety. In the context of the overall improvement noted, this is addressed in the relevant regulations.

The provider had improved staffing levels and the consistency of staffing levels. These improved staffing levels meant that each resident had one-to-one staff support every day from approximately 10:00hrs to 22:00hrs. This addressed concerns that had arisen at the time of the last HIQA inspection as to the ability of one staff to safely provide the support needed by both residents particularly in the late evening. The provider was currently monitoring the adequacy of the staff sleepover arrangement. There was one staff on sleepover duty each night. This will

be discussed again in the next section of this report when discussing risk management.

Staff had access to a programme of training. Staff attendance at mandatory, required and desired training was monitored. In the context of COVID-19 some blended training was still provided as staff awaited the full return of face-to-face training. Based on the records seen and staff spoken with all staff had completed practical or on-line training such as in safeguarding, fire safety, responding to behaviour that challenged and, a suite of infection prevention and control training. Certificates were in place confirming the completion of any self-directed training. Staff spoken with said they had received good induction following their employment and had the opportunity to shadow more experienced staff so as to familiarise themselves with the support and care provided to residents.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a complete and valid application seeking renewal of the registration of this centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time and had the skills, experience and qualifications needed for the role. The person in charge endeavoured to be actively present in the centre. The person in charge was well informed of matters arising in the centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had improved staffing levels and the consistency of staffing. Based on what the inspector read and observed these staffing levels were appropriate to the number and assessed needs of the residents. The provider was currently monitoring a pattern of resident night-time waking in the context of the sleepover staff arrangement. This will be discussed again when discussing risk management in the next section of this report.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a programme of training that included mandatory, required and desired training and training that reflected the assessed needs of the residents. For example, staff had completed training in specific manual signing techniques and in the provision of modified diets.

Judgment: Compliant

Regulation 21: Records

Any records requested by the inspector were in place. The records were well maintained and the inspector retrieved from them any information needed to inform and validate these inspection findings. For example, records of referrals and reviews with regard to resident health and well-being.

Judgment: Compliant

Regulation 22: Insurance

With its application seeking renewal of registration the provider submitted evidence of having insurance in place. Residents were advised of this insurance in their contract for the provision of services.

Judgment: Compliant

Regulation 23: Governance and management

There was evidence of improved governance and oversight that was focused on each resident and the quality and safety of the service they received. The provider had completed the actions it said it would take further to the findings of the last HIQA inspection of this service in October 2020. The inspector found good integration between systems of oversight and review, better use of data that was collated and, evidence that the governance structure was operated as intended by the provider.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The contract for the provision of services was specific to the circumstances and needs of the resident, the service and support provided and any fees to be paid.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose and function contained all of the required information and was an accurate reflection of the service. For example, the staffing and management arrangements and the range of resident needs that could be met.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on the records seen in the centre there were adequate arrangements for notifying HIQA of events such as any injury sustained by a resident.

Judgment: Compliant

Regulation 34: Complaints procedure

The person in charge said no complaints had been received since the last HIQA inspection. This was also reflected in the reports of internal reviews. The inspector saw the complaints procedure had been updated and it was readily available in the house in a format that maximised its accessibility to residents. The person in charge described systems for communicating with representatives such as regular phone contact and regular structured updates on resident well-being.

Judgment: Compliant

Quality and safety

Residents received a good quality person-centred service. The improved staffing levels and consistency of staffing promoted the individuality of the service provided. Staff maintained good oversight of resident well-being. Resident well-being and welfare was maintained by a good standard of evidence-based care and support. However, improvement was needed in the monitoring of the effectiveness of risk management controls so as to ensure and assure resident safety.

The support and care provided was informed by the personal plan. The inspector saw that the assessment of resident needs, choices and preferences was current. The plan had been updated based on the assessment findings and included the residents personal goals and objectives for 2022. It was evident that what residents achieved in 2021 had been impacted by fluctuating risks and restrictions associated with COVID-19. Records seen and the practice observed confirmed that management and staff consistently supported residents to have a good quality of life and to manage any anxieties that arose. Residents had responded very differently to their changed routines; the support provided reflected this individuality. For example, staff described how one resident found it very challenging to have to stay at home while the other resident had become very comfortable with this. One resident showed the inspector their accessible personal plan, knew what was planned for the afternoon and approached staff for assistance in setting up a scheduled video call with a peer.

It was evident from the plan that staff monitored the effectiveness of the plan. There was good access to and input from the MDT (multi-disciplinary team) in response to new or changing needs. For example, the positive behaviour support plan had been reviewed in consultation with the behaviour support team. Oversight of the plan included monitoring of the use and effectiveness of medicines including medicines prescribed on an as needed basis. Their administration was set out in a protocol and their use was monitored and analysed. At verbal feedback of the inspection findings there was discussion as to how medicine administration records could be improved so as to better support quality assurance systems.

The provision of consistent evening staffing was more appropriate to the known needs of residents and facilitated the implementation of therapeutic behaviour support strategies. However, staff and management were monitoring a pattern of resident night-time and early morning waking. There was a sleepover staff member on duty each night. Overall, staff were alerted and therapeutic support such as redirection or the provision of a snack resolved the matter. However, there had been an occasion where staff had not been awoken by the movement and actions of the resident. Staff had found the resident up and about when they commenced their waking shift; staff recorded and reported this. Consequently, there were two open medium rated risks. There was a risk assessment for this night-time waking and a risk assessment for leaving the centre without staff. Identified controls to manage these risks included the locking of final exit-doors at night and the provision of a bell

on the main front door to alert staff to its opening.

However, the inspector found a lack of vigilance in the monitoring and testing of these controls. The inspector was not assured as to the effectiveness of the controls by day and by night. On going to confirm the controls specified in the risk assessment were in place, the inspector noted the resident was unsupervised on the ground floor. The person in charge and a staff member were in the staff office on the first floor. The inspector opened and closed the front door twice and while the bell activated on each opening and closing no staff member responded to the bell or checked on the whereabouts and safety of the resident. This was brought to the immediate attention of the person in charge who was requested to address supervision, vigilance and the adequacy of the controls as a matter of priority. In addition the inspector saw that the lock was a thumb-turn device. The person in charge said that while the resident had not operated the thumb-turn device they would have the ability to do so. The day after this inspection the person in charge confirmed two additional bells to alert day and night staff had been installed at first floor level. The person in charge confirmed that the risk assessments were under review and the incident was to be discussed at a staff meeting.

The staff practice observed was in line with updated infection prevention and control guidance. Staff worked to protect residents and themselves from the risk of infection. For example, staff were seen to use the personal protective equipment (PPE) appropriate to the task and confirmed they had adequate supplies. The environment was visibly clean and there were procedures that set out for staff how often areas and items were to be cleaned. The inspector observed ready access to hand sanitising products. The available sanitary facilities meant that each resident and the staff team had their own dedicated bathrooms and hand washing facilities. Staff confirmed they were updated on any changes made to policy and practice. Staff knew what to do in the event of suspected COVID-19. Systems of review included regular audits both planned and unplanned of infection prevention and control practice. However, these reviews did not accurately reflect all of the needs of the service and therefore did not establish and ensure the appropriate arrangements were in place. For example, the requirement for explicit procedures or the provision of proprietary equipment (a spill-kit) in response to possible bio-hazards was not highlighted by reviews. In addition, explicit procedures were needed for the cleaning, drying and storage of reusable equipment.

There was evidence of good fire safety management systems. For example, the inspector saw that devices designed to close fire-resistant doors had been fitted since the last HIQA inspection. There were adequate arrangements for inspecting and maintaining equipment such as these devices, the fire detection and alarm system and the emergency lighting. The procedure to be followed in the event of fire was prominently displayed. Regular, simulated evacuation drills were convened sometimes with residents participating and sometimes not. For example, staff specific drills were convened to coincide with the recruitment of staff to familiarise them with the evacuation procedures. However, while there were regular drills and no reported obstacles to evacuating the centre, no drill report seen by the inspector demonstrated how drills were undertaken to test the ability of one staff to evacuate

both residents.

Regulation 10: Communication

The inspector saw that communication differences did not impact on the effectiveness of communication between residents and staff. Staff described and the inspector saw how staff offered choice so that residents could express their choices and preferences. Residents had access to the Internet and a range of media that they used in line with their choice and ability. Other tools in use included visuals such as a daily visual schedule and communication applications. If a resident choose not to engage with such tools this was respected.

Judgment: Compliant

Regulation 11: Visits

Residents had continued access to home and family as appropriate to their individual circumstances. The importance of such visits to resident overall well-being was recognised. Reasonable controls ensured visits to home and to the centre were safely facilitated.

Judgment: Compliant

Regulation 13: General welfare and development

The support and care provided was appropriate to the needs, interests and choices of each resident. The support provided was informed by staff knowledge of each resident, resident choice and advice from the MDT. The latter ensured the evidence base of the support provided such as engagement with external therapeutic programmes. Staff and programme facilitators monitored resident willingness to engage, their enjoyment and how they benefited from these programmes. Residents were actively supported to maintain links with their local community, with family and friends. Residents had responded very differently to COVID-19 restrictions and their changed routines; the support provided reflected this individuality.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the house was suited to the needs and number of residents living in it. The house was comfortable, homely and well-maintained. Residents had access to and utilised the garden to the rear of the house. The location of the house meant that residents could if they wished and with support from staff walk to a range of shops and amenities.

Judgment: Compliant

Regulation 20: Information for residents

The residents guide contained all of the required information such as the arrangements for receiving visitors and how to access any inspection reports.

Judgment: Compliant

Regulation 26: Risk management procedures

There were identified risks to resident safety. The inspector found a lack of vigilance in the monitoring and testing of controls. The inspector was not assured as to the effectiveness of the controls by day and by night.

Judgment: Not compliant

Regulation 27: Protection against infection

There was a requirement for explicit procedures or the provision of proprietary equipment (spill-kit) in response to possible bio-hazards. In addition, explicit procedures were needed for the cleaning, drying and storage of reusable equipment.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While there were regular simulated drills and no reported obstacles to evacuating the centre, no drill report seen by the inspector demonstrated how drills were undertaken to test the ability of one staff to evacuate both residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Both the assessment of needs and the personal plan were current. There was evidence of MDT input into the plan. Residents were provided with an accessible plan. The personal plan included the residents personal goals and objectives to be achieved in 2022.

Judgment: Compliant

Regulation 6: Health care

Staff maintained consistent oversight of resident health and well-being and ensured residents had good access to the clinicians and services that they needed. For example, their general practitioner (GP), speech and language therapy, occupational therapy, dental care and specialist hospital based services. Staff maintained records of clinical referrals and reviews.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour support plan was current. Based on records seen there was access as needed to psychology, psychiatry and behaviour support. Staff had completed training in strategies for preventing and responding to behaviour of concern and risk. There were effective systems for monitoring interventions such as the use of medicines when therapeutic interventions did not work.

Judgment: Compliant

Regulation 8: Protection

There were no active safeguarding concerns. Residents lived compatibly together

but also had very individualised routines. Staff had completed safeguarding training and were aware of their responsibility to protect residents and how to report any concerns they may have.

Judgment: Compliant

Regulation 9: Residents' rights

The routines of the house and the support provided reflected the individuality, needs, abilities and choices of each resident. Staff described and the inspector saw how residents were offered choice and supported to make decisions in their daily life. Residents were supported to exercise their spiritual beliefs if this was important to them. The inspector saw that communications about and records in relation to the care and support provided were conducted and created with respect for resident privacy and dignity.

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 | |
| Registration Regulation 5: Application for registration or renewal of registration | Compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| Quality and safety | |
| Regulation 10: Communication | Compliant |
| Regulation 11: Visits | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

Compliance Plan for Caislean OSV-0005361

Inspection ID: MON-0027384

Date of inspection: 25/01/2022

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

| Regulation Heading | Judgment |
|---|-------------------------|
| Regulation 26: Risk management procedures | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>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. This will be ensured as follows:</p> <p>A full comprehensive review of risk assessments for the safety of one resident has been completed. This review included ensuring all controls in place are appropriately identified and assessed, well managed/ controlled, and any additional controls required are identified and actioned in a timely manner. [Complete]</p> <p>The identified risk has been actioned as follows:</p> <ul style="list-style-type: none"> • 2 additional bells have been electronically wired to the front door to ensure staff are notified when the front door is opened. [Complete] • Team meeting held to discuss the importance of staff vigilance in the monitoring and testing of controls in place to ensure the safety of one resident. [Complete] • Restrictive Practice protocol completed and reviewed by Clinical Psychologist to ensure the safe use of front door bell system. [Complete] • PIC to carry out regular unannounced inspections of the front door system to ensure adequate staff vigilance in the monitoring and testing of controls in place to ensure the safety of one resident. The PIC will ensure the risk assessment will be updated to reflect and monitor these additional controls [01/05/2022] | |
| Regulation 27: Protection against infection | Substantially Compliant |

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| | |
| <p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <p>The registered provider shall ensure that (27) the 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; as follows:</p> <ul style="list-style-type: none"> • The PIC has reviewed procedures for reusable equipment for one resident – this review was completed with the clinical guidance of a specialist nurse and a protocol developed for the procedures for cleaning, drying and storage of the equipment. Risk assessment now reflects the protocol in place for guidance for the cleaning, drying and storage of reusable equipment. [Complete] • Spill Kit has been purchased and now on site in the event of possible bio-hazard and procedure for the use of Spill Kit has been developed. [Complete] • Infection Prevention and Control Risk assessment has been updated to include the provision of a spill kit in response to possible bio-hazards. [Complete] | |
| Regulation 28: Fire precautions | Substantially Compliant |
| <p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28(3)(d): The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. This will be ensured by:</p> <ul style="list-style-type: none"> • The PIC will ensure that effective fire safety management systems are in place within the Designated Centre and ensure they are monitored and reviewed with staff team regularly. • The schedule for fire drills for the coming year has been reviewed to ensure there is a mix of day and night drills and to test the ability of one staff to evacuate both residents if lone working. [Complete] • A fire drill that tested the ability of one staff to effectively evacuate individuals within their home was successfully completed. [Complete] • The PIC will ensure the associated risk assessment is updated to reflect all controls and is monitors regularly. [Complete] | |

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 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. | Not Compliant | Orange | 01/05/2022 |
| 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 | Substantially Compliant | Yellow | 18/02/2022 |

| | | | | |
|---------------------|--|-------------------------|--------|------------|
| | published by the Authority. | | | |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Substantially Compliant | Yellow | 21/02/2022 |