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:	Announced
Date of inspection:	11 August 2022
Centre ID:	OSV-0007483
Fieldwork ID:	MON-0028802

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 a social care worker 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
Thursday 11 August 2022	09:15hrs to 17:45hrs	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 the majority of their assessed needs. Notwithstanding this, significant improvements were required in fire safety, healthcare, staffing, and training and staff development. In addition, improvements were required in relation to positive behaviour support, premises, governance and management, protection against infection, and notification of incidents. These areas are discussed further in the next sections of the report.

The inspector had the opportunity to meet both residents living in the centre. Residents for the most part had alternative communication methods and they either did not share their views with the inspector or did so in a limited capacity. They were observed for a time during the course of the inspection.

On the day of inspection, one of the residents was preparing to go swimming with two staff members. They communicated to the inspector that they liked the food they ate and that the staff members that worked in the centre were nice. When asked if they liked their home they gave a thumbs up sign. Staff with the help of a behaviour support therapist, were attempting to slowly expand on their opportunities for new experiences, such as horse riding. In addition, the aim was to support them in coping with changes related with trying those new activities.

The other resident was observed spending some time in the garden and practicing on their keyboard. They were getting ready to go out for lunch in a nearby hotel and then were going to attend the cinema later that day.

The centre was made up of two apartments with one resident living in each apartment. The centre appeared clean, tidy and had adequate space for privacy and recreation for residents. Both residents had their own bedroom and rooms were individually decorated to suit their tastes, and personal pictures or favourite television characters were displayed on their walls. However, some improvement was required to section areas of paintwork and slight repair was required to some areas of the centre. These areas will be discussed further in the report. Due to restrictive practices in place for one resident's safety, it took away from the homely appearance of their apartment. This had been self-identified by the provider and the person in charge was looking at ways to promote a more homely feel to the apartment.

The property had a wraparound garden. One resident had a trike for use around the property. There were some potted flowers and hanging baskets displayed in the garden. One resident had a particular chair they liked to use to relax in the garden. Each resident had their own transport in order to access external activities and appointments.

There were two staff members working in each apartment on the day of inspection.

Staff spoken with demonstrated that they were familiar with the residents' care and support preferences. They were observed to engage with residents in a manner that was friendly, attentive and with some friendly interactions, for example when talking about if staff in the centre were good cooks. Resident and staff interactions appeared to be relaxed.

As part of this inspection process, residents' views were sought through questionnaires provided by the Health Information and Quality Authority (HIQA). The provider had forwarded the questionnaires to family representatives, however, at the time of the inspection the responses had yet to be received.

The provider had also sought resident and family views on the service provided to them by way of an annual questionnaire in 2021. Feedback received from families and residents indicated that people were satisfied with the service.

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 systems in place to ensure safe quality care was being delivered to the residents to meet the majority of their assessed needs. However, improvements were required to ensure the centre was adequately resourced each day. Additionally, improvement was required to governance and management, staff training and the notification of incidents that occurred within the centre.

There was a statement of purpose available as per the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations) and it contained the majority of the prescribed information required. Any omitted information was amended and an updated version submitted to HIQA.

There was a defined management structure in place which included the person in charge and they in turn reported to two senior managers that participated in the management of the centre. The person in charge was employed in a full-time capacity in the organisation and they had the experience and qualifications to fulfil the role.

The provider had carried out an annual review of the quality and safety of the service provided and there were arrangements for auditing of the centre carried out on the provider's behalf on a six-monthly basis. From a review of the annual review and the six-monthly visits, the inspector found that the majority of actions identified had been followed up on and outstanding actions were still within noted timescales. However, not all completed actions had been marked as complete on the audit

documentation. This was brought to the attention of person in charge on the day of inspection and they confirmed it was a documentation oversight, and would ensure all actions would be closed off on the audit form itself going forward. There were other local audits conducted in areas, such as vehicle checks, health and safety, finance, infection prevention and control, fire safety, and medication. While the provider's own auditing systems had picked up on a number of the identified issues observed on this inspection, not all areas had been identified or managed within reasonable timescales, therefore this required review.

From a review of the rosters, the inspector saw that there was an actual and planned roster in place. The inspector observed that the centre was operating below their whole time equivalent (WTE) as per their statement of purpose, for one apartment. There was an over-reliance on relief and agency staff, albeit consistent staff, to fill rostered shifts. In addition, from speaking with the person in charge, some staff members and from a review of records, the WTE staffing was not adequate in assuring one resident could leave their apartment to take part in external activities for three days per week. On those days when there was one staff member on duty, the resident could only leave their apartment to go for a short walk or drive, as two staff were required for longer or further away activities. The need for extra staffing resources had been highlighted by the person in charge to senior management. One new staff member was in pre-employment checks at the time of this inspection, however, this new addition would not fully solve the staffing resource issue. Staff personal files were not reviewed on this inspection.

Staff had access to necessary training and development opportunities in order to carry out their roles effectively and to meet residents' assessed needs. For example, staff training included, fire safety, safeguarding of vulnerable adults, medication management, and infection prevention and control training. However, it was difficult to ascertain if staff training was upto date from review of the training records. From documentation viewed, the inspector saw that a number of staff members required refresher training in a large number of areas such as fire safety, managing behaviour that is challenging, epilepsy and emergency medication, feeding, eating drinking and swallowing training, medication management, safeguarding, and infection prevention and control training.

Some staff meetings were occurring in the centre, however, they were not consistently occurring. Some staff members spoken with said that they felt listened to and supported by the person in charge and would feel comfortable raising concerns if required. In addition, there were formalised supervision arrangements in place. The person in charge had plans to increase the frequency of the formal supervision as it had been occurring on the minimum frequency level in line with the organisational policy.

While the Chief Inspector of Social Services (the Chief Inspector) was notified in line with the regulations regarding occasions in which a restrictive practice was used in the centre, the person in charge was late submitting two quarterly notifications within the prescribed timescale.

Registration Regulation 5: Application for registration or renewal of registration

As required by the registration regulations, the provider had submitted an application to renew the registration of the centre along with the required prescribed documents.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity in the organisation. They had the experience and qualifications to fulfil the role. They managed four designated centres, one of which was the organisation's self-isolation unit, if required. The person in charge visited the centre each week and was also involved in reviewing audits completed by staff members. Staff members spoken with said they felt listened to, supported by the person in charge, and could raise concerns if required.

Judgment: Compliant

Regulation 15: Staffing

From a review of the rosters, the inspector saw that there was an actual and planned roster in place. The centre was operating below their whole-time equivalent (WTE) as per their statement of purpose.

In addition, the WTE of staffing was not adequate in ensuring one resident could leave their apartment to take part in external activities for three days per week. On those days when there was one staff member on duty, the resident could only leave their apartment to go for a short walk or drive, as two staff were required for longer or further away activities.

Judgment: Not compliant

Regulation 16: Training and staff development

It was difficult to ascertain from a review of staff training records, if staff training was up to date. From documentation viewed a number of staff members required refresher training in a large number of areas such as fire safety, managing

behaviour that is challenging, epilepsy and emergency medication, feeding eating drinking and swallowing training, medication management, safeguarding, and infection prevention and control training.

Judgment: Not compliant

Regulation 22: Insurance

The provider had taken out a contract of insurance against injury to residents and against other risks in the centre, such as property damage.

Judgment: Compliant

Regulation 23: Governance and management

There was a defined management structure in place and the provider had carried out an annual review of the quality and safety of the service provided. In addition, there were arrangements for auditing of the centre carried out on the provider's behalf on a six-monthly basis. There were other local audits conducted in areas, such as infection prevention and control, fire safety, and medication. The provider's own auditing systems had picked up on a number of the identified issues observed on this inspection, however not all areas had been identified or managed within reasonable timescales, therefore this required review. In addition, only some staff meetings were occurring in the centre and they were not regularly occurring.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose available as per the regulations and it contained the majority of the prescribed information required. Any omitted information was amended and an updated version submitted to HIQA.

Judgment: Compliant

Regulation 31: Notification of incidents

While the Chief Inspector was notified in line with the regulations regarding

occasions in which a restrictive practice was used in the centre, the person in charge was late submitting two quarterly notifications within the prescribed timescale.

Judgment: Substantially compliant

Quality and safety

Overall, residents in this centre were in receipt of care and supports that were individualised and focused on their needs and, for the most part, residents enjoyed a good quality of life in the centre. However, the arrangements in place to contain a fire and ensure a safe evacuation of the centre needed significant review. Further improvements were required in relation to healthcare, positive behaviour support, premises, and protection against infection.

There were fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment. Each resident had a personal emergency evacuation plan (PEEP) in place and regular fire drills were being conducted in the centre. However, improvement was required as the self-closures on two fire containment doors were broken and one emergency light was not working. The main entrance and the hall door to one apartment were locked and there was no alternative method other than keys of gaining access to outside, instead there was a reliance on staff to have the keys on their person. This posed a potential risk to the resident as the inspector was not assured that the resident would be able to evacuate in the event of a fire, if staff were left incapacitated for any reason or indeed if they did not have the key on their person.

Overall, residents had timely access to a range of allied healthcare professionals in order to meet their identified healthcare and mental health needs. It was evident that the majority of residents' healthcare needs were monitored within the centre on an ongoing basis. However, as per the last HIQA inspection, one resident did not have access to mental health care services, which was their support requirement, prior to and following admission to the centre. While there had been some follow up undertaken by the provider, there were some delays in the progression and follow up, and there was no definite arrangement for the resident to gain access to this required service. In addition, one resident required a review of their speech and language assessment, as it was due for review since May 2020.

There were arrangements in place to assess residents' needs and review the effectiveness of the support plans in place for residents and with input from allied healthcare professionals as appropriate. There were personal plans in place to support residents with identified needs including communication plans, epilepsy care plans, and speech and language dietary plans.

The inspector reviewed the arrangements in place to support residents' positive behaviour support needs. Residents had access to psychologists and behaviour therapists in order to support them to manage their behaviour positively if required.

There was a positive behaviour support plan in place for one resident as appropriate, to guide staff on to how best to support them. Staff members spoken with were familiar with the strategies within the plan. However, one resident's behaviour support plan required a more formal structure, as information was in several places and some sections in one document had yet to be completed.

While there were restrictive practices in place, these were assessed as necessary for residents' safety and they were subject to review. Restrictions in place included, when required medication was used to support a resident with their anxieties and when some internal and external doors were kept locked. Consent was provided by family representatives for restrictive practices in place.

There were arrangements in place to protect residents from the risk of abuse. There was a safeguarding policy and staff were appropriately trained, however, from training records it appeared some staff required refresher training. This is being addressed under Regulation 16: Training and staff development. There were systems in place to safeguard residents' finances, such as finance audits which were completed bi-monthly and finances were counted by staff twice daily. There were clear intimate care plans in place for residents which guided staff on how best to support them and inform staff of their preferences. There was no open safeguarding incidents in the centre at the time of the inspection.

The inspector found that residents had opportunities to make choices about their care and how they spent their day which promoted their rights. There were weekly residents' meetings occurring. There was easy-to-read information on rights available in the centre and staff used resident meetings as opportunities to discuss that information. Staff members spoken with appeared familiar with residents' preferences and assessed needs.

There was a residents' guide prepared and a copy available to each resident that contained the required information as set out in the regulations.

From a walkabout of the centre, the inspector found the house to have adequate space and was laid out to meet the needs of the residents. However, some improvements were required to the decoration of the premises. For example, some internal paint work was scuffed or required to be touched up, such as some kitchen presses. In addition, there were some minor holes in walls that required to be filled, such as from an old blind in a bedroom.

Risk management arrangements ensured that risks were identified, monitored and regularly reviewed. There was a policy on risk management available and the centre had a risk register in place. Risk assessments were within review periods and there were a number of centre risk assessments along with individualised risk assessments in order to support residents and keep them safe. The inspector observed that both the centre's vehicles were recently serviced, were insured and had an up-to-date national car test (NCT).

The inspector reviewed arrangements in relation to infection control management in the centre. There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19. The centre had a

contingency plan in the event of a suspected or confirmed outbreak of a notifiable disease. However, improvements were required as slight mildew was observed in three places in the centre. For example, on the wall in the utility room of one apartment. Some mops and buckets were inappropriately stored outside of the designated centre. In addition, more consideration was required to the storage of items in the centre as some PPE was being stored on a concrete floor of the hotpress.

Regulation 17: Premises

From a walkabout of the centre, the inspector found the house to have adequate space and was laid out to meet the needs of the residents. However, some improvements were required to the decoration of the premises. For example, some internal paint work was scuffed or required to be touched up and some minor holes in walls required to be filled.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide prepared and a copy available to each resident that contained the required information as set out in the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management arrangements in place ensured that risks were identified, monitored and regularly reviewed. There was an organisational risk management policy available and the centre had a risk register in place. Individual and centre specific risk assessments were within review periods. The inspector observed that both the centre's vehicles were recently serviced, were insured and had an up-to-date national car test (NCT).

Judgment: Compliant

Regulation 27: Protection against infection

There were arrangements in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19. The centre had a contingency plan in the event of a suspected or confirmed outbreak of a notifiable disease. However, some improvements were required, for example, slight mildew was observed in three places in the centre, such as on the silicone of the shower floor in one apartment. The mops and buckets from one apartment were inappropriately stored outside of the designated centre. In addition, more consideration was required with regard to the storage of items in the centre, as some PPE was being stored on a concrete floor of the hotpress.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While there were fire safety management systems in place, significant improvements were required. For example, the main entrance and the hall door to one apartment were kept locked and there was no alternative method other than keys of gaining access to outside, instead there was a reliance on staff to have the keys on their person. The inspector was not assured that the resident would be able to evacuate in the event of a fire if staff were left incapacitated. In addition, two self-closures on fire containment doors were broken and one emergency light was not working.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need completed and there were arrangements for reviewing the efficacy of the support plans in place with input from allied healthcare professionals as appropriate. Identified needs had personal plans in place to support residents, including communication plans, epilepsy care plans, and speech and language dietary plans.

Judgment: Compliant

Regulation 6: Health care

While for the majority of identified healthcare and mental health needs residents' needs were monitored within the centre on an ongoing basis. However, as per the last HIQA inspection, one resident did not have access to mental healthcare

services, as was their support requirement, prior to and following admission to the centre. While there had been some follow up undertaken by the provider, there were some delays in the progression and further follow up, and there was no definite arrangement for the resident to gain access to this required service at the time of the inspection. Additionally, one resident required a speech and language assessment review, as it was due for review since May 2020.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents had access to psychologists and behaviour therapists as required, in order to support them to manage their behaviour positively. There was a positive behaviour support plan in place for one resident, as appropriate, to guide staff as to how best to support them. However, one resident's behaviour support plan required a more formal structure, as information was in several places and in addition some sections of documentation had yet to be completed.

There were restrictive practices in place that were deemed necessary for residents' safety and they were subject to regular review. For example, some internal and external doors were kept locked. Consent for the restrictive practices in place was provided by family representatives.

Judgment: Substantially compliant

Regulation 8: Protection

There was a safeguarding policy in place and staff spoken with were aware of the procedures to follow in the event of an incident of abuse occurring in the centre. Residents' finances were safeguarded by the completion of bimonthly financial audits and finances were counted twice daily by staff members. There were clear intimate care plans in place to guide staff on how best to support residents and inform staff of their preferences.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that residents had opportunities to make choices about their care and how they spent their day which promoted their rights. There were weekly

residents' meetings occurring in the centre and there was easy-to-read information on rights used by staff at those meetings to promote understanding of the information.
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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Delvin Centre 4 OSV-0007483

Inspection ID: MON-0028802

Date of inspection: 11/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Recruitment in progress to allow designated centre to operate at WTE as per statement of purpose. • Business case submitted from Area Director to Regional Director to increase WTE of the designated centre. Review of overall staffing resources undertaken to allow for incremental increase in WTE available from 30/09/2022	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Full review of staff training requirements for the designated centre undertaken by PIC and report and risk management plan submitted to Area Director. • Schedule of outstanding training created with timeline, report to be submitted to Area Director for sign off when completed with deadline of 30/11/2022.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • Full review of all internal audits and outstanding actions to be completed by PIC by 30/11/2022 • Annual team meeting schedule for designated centre submitted by PIC to Area Director for sign off by 30/09/2022.

Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • As of 23/09/2022, advance notice of requirement to submit quarterly notifications in line with schedules as per regulations is issued to all PICs from the office of the Area Director. • Completion of notifications are notified to office of Area Director on or before schedule return date by each PIC.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Work request for internal paintwork and filling of minor holes in wall submitted to maintenance department for completion.	

Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • PIC has developed a local protocol to ensure management of the presence of mildew in the centre. • Mops and buckets are now stored in outside storage unit • PPE is now stored securely in outside storage unit.	

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Thumb turn locks scheduled to be installed on main entrance door, hall door and staff room door.
• Self-closures on fire doors scheduled to be replaced.
• Emergency light has been replaced.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Re referral of resident to local mental Health (Intellectual Disability) Team submitted by PIC.
• Senior management team in organization have escalated concern over absence of mental health services and support with senior management in the Health Service Executive local CHO area - this escalation is ongoing.

• Area Director actively exploring private healthcare route for resident as an interim measure
• Referral to Speech & Language has been made for resident assessment review.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Full review of residents behaviour support plan has been undertake by PIC and Behaviour Support Therapist to ensure greater structure and allow document be more accessible.
• Action plan set for staff team to ensure completion of documentation as required.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/11/2022
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	30/11/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	17/10/2022

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	17/10/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2022
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 published by the Authority.	Substantially Compliant	Yellow	30/09/2022
Regulation 28(2)(c)	The registered provider shall	Not Compliant	Orange	18/10/2022

	provide adequate means of escape, including emergency lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	17/10/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	23/09/2022
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	20/01/2023
Regulation 7(5)(a)	The person in charge shall ensure that, where	Substantially Compliant	Yellow	31/10/2022

	a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			