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:	Avalon House
Name of provider:	Health Service Executive
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	28 June 2023
Centre ID:	OSV-0003694
Fieldwork ID:	MON-0040306

About the designated centre

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

This designated centre provides full-time residential care for seven adults with an intellectual disability, both male and female and over the age of eighteen. The centre is a large detached bungalow a few kilometres outside the nearest town. The centre comprises fifteen rooms including two small storage rooms and a lobby area. There is a kitchen, dining room, sitting room, utility room and seven bedrooms, all with en-suite facilities. There is one separate bathroom and one wheelchair accessible toilet. The centre has a large garden and patio area at the back of the house. It has its own transport; a wheelchair accessible vehicle and a people carrier. The person in charge works full-time in this centre and the staff team includes both nurses and health care assistants. Staff provide support to residents during the day and at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Wednesday 28 June 2023	19:00hrs to 22:45hrs	Julie Pryce	Lead
Wednesday 28 June 2023	19:00hrs to 22:45hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

This inspection was conducted in the evening commencing at 19.00 hours in order to monitor on-going compliance with the regulations, and to review the quality and safety of care and support provided at evening time.

On arrival at the designated centre the inspectors observed that there were sufficient numbers of staff to meet the needs of residents however, they observed a lack of activities for residents, and were concerned about the level of interaction between staff and residents during the inspection.

Throughout the evening several of the residents were unoccupied, some in their rooms, and some in living areas with no meaningful activities provided. This is discussed in more detail later in this report.

An initial 'walk around' of the centre conducted by one of the inspectors revealed various aspects of the premises to be either unsuitable to meet the needs of residents, or to be utilised in a way which did not maximise the potential use. This included an outside cabin which the provider had stated following previous inspections would be used as an activity area, and also as an area for residents with behaviours of concern to de-escalate. This cabin was not in use, and was used as a storage area and was not in a state of cleanliness or furnishing to be used. Fire compliance certification for this structure was not in place, despite the construction having been completed many months previously.

During the course of the inspection, there was a change-over of shift, and the day staff left to be replaced by the night staff. As the day staff left there were various brief interactions with residents, many of whom were observed to make fond farewells to the departing staff, with hugs and handshakes, so that it was clear that there was a good relationship between some of the staff and the residents.

The night staff were observed to be offering choice to residents for their evening supper, and some residents who were not in their rooms told the staff what they would like, and this was provided to them. However, other than this service, and personal care being offered to residents, no other meaningful activities or occupations were offered to most of the residents.

One resident, who did not have verbal communication and was a wheelchair user, spent the entire evening in their wheelchair in front of a television, and the inspectors observed that this person had no interest at all in the television. One of the inspectors interacted with this resident whilst having a light hearted conversation with another resident, and he reacted with giggles and smiles, and clearly enjoyed the interaction. However, one of the inspectors who was reviewing documentation from one of the living areas, observed this resident throughout the evening, and there was no such interaction with any staff members.

One of the residents who inspectors were informed had engaged in behaviours of concern for a period of time just prior to the commencement of the inspection was accompanied by staff in the garden area whilst they enjoyed their vape, and was later observed to be supported by staff to engage in household tasks, which was something that they enjoyed doing and was reported as giving them a sense of purpose. However, another resident spent the entire evening at the kitchen table, and had her head in her arms when inspectors arrived. There was some brief conversation between the resident and the day staff, and the resident was clearly comfortable and familiar with some of them. They were observed to call a staff member over and whisper a request or question, and were visibly pleased with the response. However, after 8pm. other than the previously mentioned offer of supper, no further interactions took place between staff and this resident.

Whilst residents were unoccupied after 8pm, and whilst the two residents in the dining area and TV areas were still up and unoccupied, night staff were observed to be wiping kitchen press doors, a task which could have been completed during the night, as staff were waking night staff. Inspectors were concerned about the lack of oversight of the evening activities of residents, and the best use of staff time throughout the night shift.

The review of documentation conducted by inspectors showed that there were some examples of good practice. For example, a detailed positive behaviour support plan was in place for one resident which included well prepared social stories, including explanations for some of the boundaries that were necessary to ensure the safety of all residents, for example a social story in relation to not vaping or smoking in the house. One of the inspectors spoke to this resident, and the resident knew what was in this plan, and could explain the reason for being asked to vape outside.

However, all of the personal plans and care plans presented to the inspectors were out of date and included guidance that was no longer relevant due to the changing needs of residents. This documentation is further discussed later in this report.

Of further concern were various inaccuracies identified in the record keeping of care delivery and medication management. There were significant gaps in care delivery which were not recorded appropriately.

Overall the inspectors were not assured that residents were supported to have a good quality of life, or to have all of their needs met, or that previous assurances from the provider in relation to improvements were implemented.

The next two sections of the report outline 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 residents lives.

Capacity and capability

There was a clearly defined management structure, and the provider had made arrangements to ensure that key management and leadership roles were appropriately filled. However, there was insufficient evidence of effective oversight of this designated centre.

Documentation was not in order, both in relation to care planning and in recording. Incidents were recorded in an ad hoc manner in various places, so that inspectors could not determine any effective way of monitoring incidents. There was no evidence of learning or follow up actions being identified for incidents that had been recorded as complaints.

The issues relating to lack of current information in care plans, and the presence of out of date information had been identified as an issue at the inspection of this centre two years ago on 7 October 2021, and assurances were given following this inspection that the issues would be attended to. The inspection of 12 April 2022 found that significant improvements had been made, however, these improvements had not been maintained.

Overall, oversight of the care and support offered was insufficient to ensure a meaningful life for residents, or to monitor the daily care and support being offered to residents.

Regulation 23: Governance and management

There was a lack of oversight of the evening activities and task allocation of staff, and an ineffectiveness of management in ensuring that premises were improved as had been agreed in the compliance plans submitted in response to previous inspections. There were also significant concerns about the accuracy of documentation in this designated centre.

A meeting was held between HIQA and the provider of this designated centre on 15 May 2023, at which a warning letter was issued to the provider. This warning letter related to the provider operating outside of their conditions of registration. A restrictive condition had been applied to the registration of the centre following the inspection of 12 April 2022 due to repeated failures of the provider to respond appropriately to non-compliance in ensuring the safety and quality of life of residents which were negatively affected by the behaviours of concern of other residents. The restrictive condition had not been adhered to, and the provider had not applied to change the conditions of their registration within the required timeframe. Following this meeting the provider submitted an application to vary this condition, and this application was granted which meant that the original timeframe had been extended by a year.

Furthermore, an external structure in the garden of the designated centre, which had been designed to be used as an activation area, and as an area which residents needing to de-escalate from episodes of behaviour of concern might utilise, was still

not in use.

Further issues of concern included the monitoring of staffing availability and the consistent communication with the staff team. On the day of the inspection the only staff nurse on duty had attended a training course, and no nursing cover was provided. This meant that essential nursing care relating to healthcare and medication management were not provided to at least one resident during the afternoon. Further details are outlined under Regulations 6 and 29 of this report where the records were inconsistent with the presence of the registered nurse.

The records of staff meetings were reviewed by the inspectors, and there were significant gaps in these records. Staff spoken with stated that staff meetings were to occur monthly however, while there was a schedule of meetings in place there were only minutes available for 4 out of the 12 months and only one record with a date in 2023.

In addition there were similar gaps in the records relating to residents' meetings which were supposed to occur weekly. The records of residents meetings included identical comments on subsequent records, which meant that the records were not meaningful and raised concerns about the effectiveness of these meetings. This lack of minutes meant that the inspectors were not assured that residents or staff were communicated with on a regular or consistent basis.

The inspectors had serious concerns about record keeping throughout the inspection. For example, healthcare provision that needed to be provided by a registered nurse was signed off as being completed on times during the afternoon when there was no nurse present in the centre, and in fact the care had not been given until later. This related both to both medication and to the management of percutaneous endoscopic gastroscopy (PEG). Both of these issues are discussed in more detail later in this report.

Incidents of concern were not recorded in a consistent and appropriate way. Behaviours of concern which had an impact on others were recorded as complaints from other residents, and there was no record of them in the incident records. Other incidents only recorded in the complaints log included an incident where a resident attempted to leave the centre. This was inappropriately recorded as a complaint, and there was no reference to it in the incident records. The records in the complaints log did not make any reference to actions taken to prevent recurrence, or to any learning to be shared from the incidents. It was therefore unclear as to how the person in charge would have clear oversight of the incidents and associated risks in the designated centre.

Judgment: Not compliant

Quality and safety

The systems in place were insufficient to ensure that residents were supported to have a comfortable life, and to have their needs met. Each resident had a personal plan in place, however, these plans were either out-of-date, or did not include sufficient information as to guide staff in the delivery of care and support to residents.

Observations throughout the inspections indicated that residents were not occupied in a meaningful way in the evenings, and there was insufficient evidence of the rights of residents in terms of choice and consultation being upheld.

Healthcare was not effectively monitored and managed for some residents, and while some good practices were found in relation to 'as required' medications, there were significant failings in the recording of the administration of medication on the day of the inspection.

The layout of the premises remain inappropriate to meet the needs of residents, particularly because of the impact of behaviours of concern of some residents on others, in the absence of an available area of the house where residents might go to de-escalate. Although the impact of behaviours of concern had improved significantly since the previous inspection, the risk to other residents had not been fully mitigated because of this.

Regulation 13: General welfare and development

As previously mentioned, the inspectors were concerned about meaningful occupations for most of the residents during the evening. Several of the residents were observed to be without any activities or interactions for significant periods during the three hours between 7pm and 10 pm that evening.

One person was placed in their wheelchair in front of the television, and was observed by one of the inspectors to have no interest in the TV, but to be watching another resident in the garden area for short periods of time, and to be attempting to turn their head to observe the kitchen/dining area for some of the time. Otherwise they appeared to have nothing that interested them.

Another resident spent their whole evening at the kitchen table in their wheelchair. They had a brief chat with a staff member early in the evening, and again when they called a staff member and had a whispered conversation with them, following which the resident appeared to be happy with the outcome. This resident was keen to chat, and it was clear that this was a preferred activity. However, no staff members had any further interaction with them.

Additional concerns were raised during the course of the inspection about meaningful activities during the day. Of particular concern was a resident whose condition had changed significantly recently. One of the inspectors requested the activation records for this resident, but there was no immediately available daily or weekly record, such as an activity tracker, or a retrospective timetable. The

inspector therefore read the daily notes for the three days prior to the inspection, and found entries stating that the resident had been in the sitting room, or had a walk in the garden. As this resident was immobile and had particular needs relating to their current deteriorating condition, the inspector reviewed all available records for just over a two week period prior to the date of the inspection in an attempt to ascertain the activities for this resident. On 1st and 2nd June the resident had been taken out, for a haircut and for a park walk. From the records until 16th June, the only other outing was on the 15th June, where the entry said 'short drive'. Other entries mainly referred to 'a walk around the house' or being in the lounge or in their comfort chair. There were two entries on the 11th and 16th June that referred to music therapy and sensory aids. Given the lack of evidence to support these activities, the inspectors were concerned that this referred to the resident having a particular attachment to two soft toys that they had observed to be, one in each hand, that the resident used when feeling unhappy or stressed. The inspectors were therefore concerned about the support for a meaningful life for this person.

Judgment: Not compliant

Regulation 17: Premises

The layout of the designated centre was not appropriate to meet the needs of residents, and various areas of the house required attention.

One for the residents whose behaviours of concern, when they occurred, had a significant negative impact on the others, had been identified as needing individual accommodation. Pending the provision of this accommodation, which is planned to be an individual apartment in an extension to the current building, the interim plan was to utilise the outside cabin structure as an activity room, and an area where the resident could go to de-escalate. This cabin was not in use, and was not in a state of readiness for use. It was unclean and contained items that were in a state of disrepair. At the meeting held after the inspection to provide feedback on the findings, the provider reported that the delay was due to the difficulty in obtaining fire safety certification, which had originally been applied for over a year ago and had not been obtained.

There were unclean windows throughout the centre, and other areas required attention for example, the linen storage room, the electrical press, the laundry room and the smoking shed used by one of the residents. All of these areas were cluttered and required a deep clean.

The storage of mop heads was not well managed, and the inspectors observed a wet used mop head on the draining board beside a box of disposable gloves in the utility area.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

One of the residents was in the process of transferring to another designated centre operated by the provider. However, staff were unable to present a transition plan for this resident, so that it was unclear as to whether this was being managed appropriately. Staff reported that there had been at least one visit by the resident to their new home, but there were no further records.

The inspectors spoke to the resident who knew about the proposed transition, but did not know when this was planned for. Staff engaged by the inspectors also were unaware of the timeframe, so were not in a position to support this resident with the proposed move.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Due to the nature of this inspection which took place in the evening, and was of a shorter duration than a usual inspection, only an example of medication management was inspected.

A review of the documentation relating to 'as required' PRN medication for one of the residents found the information to be in accordance with the information included in the positive behaviour support plan, and that it had only been administered on three occasions in the previous quarter. This indicated an improvement on the reliance on this medication since the previous inspection.

However, the inspectors found that a medication for another resident that was due to be administered at 3pm was recorded as being administered at that time, even though the only registered nurse on duty at that time was on a training course until later in the afternoon. There was no information in the recording sheet that a delay had occurred. The night staff reported that they knew this because they were told it at the handover between shifts at 8pm, and that they were delaying the next dose accordingly.

This was a further indication of the inaccuracy of recording in this designated centre, and was of particular concern due to the nature of the medication concerned.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors requested the current personal plans, and folders were presented. It was apparent that some of the care plans in these folders were not regularly reviewed, and that the care plans were out-of-date and included guidance for staff that was no longer relevant, given the changing needs of residents.

For example, one of the care plans referred to supporting the activities for a resident that they used to engage in a year ago, but because of their changing needs were now irrelevant. The inspectors requested current care plans from both the day staff and the night staff, and these were the only folders presented. This resident was found to lack any meaningful activity for significant lengths of time, as further discussed under regulation 13, so the lack of a current care plan was having a negative outcome for this person.

As the information in the sample of care plans had not been reviewed for significant periods of time, some of them for a year, one of the inspectors asked staff how they would be sure that they were aware of the current information, and they responded that they would rely on the handover from the previous staff shift. This practice does ensure compliance with the regulations.

Judgment: Not compliant

Regulation 6: Health care

Some of the care plans giving guidance to staff in the delivery of healthcare were not current, as mentioned under Regulation 5. Others did not provide sufficient guidance for staff to ensure safe and appropriate delivery of care.

An example of this was the care plan for the management of pressure areas for a resident with limited mobility. This care plan instructed staff to support the resident by 'regular monitoring of my pressure areas'. There was no further instruction available, no information about how to prevent a breakdown of pressure areas, and no guidance in relation to identifying a developing issue in tissue viability.

The regular healthcare of this residents was reviewed by the inspectors. This person required regular feeding via a percutaneous endoscopic gastroscopy (PEG). The inspectors had been informed that the only nurse on duty that day had been assigned to go on a training course during the afternoon, and had not been replaced by another nurse. As the only member of staff qualified to administer this feeding, it was clear that the 4pm feed was either missed or late. However, the record was signed to say that this feed had taken place at the allocated time.

This resident also required fluid intake to be given at regular times by a registered nurse, and again the records indicated that this hydration was administered at a

time when the registered nurse was not on the premises. It was therefore unclear to the inspectors whether this fluid had been given late, or at all.

Another resident had had seven falls since December 2022, and had sustained an ankle injury and a fractured finger during this time, and at the time of the inspection was in an orthopaedic boot to support their ankle injury. There was a risk assessment in place, and various options for the cause of these falls had been considered. The resident had been prescribed a walking aid to help to prevent the falls, however, the risk management plan was vague, and did not give sufficient guidance to staff. It stated that a required improvement was 'an education piece regarding the use of a walking aid'. There was no further guidance presented to the inspectors. The resident told one of the inspectors that they were nervous about using this aid, so it was apparent that a significant part of the required support had not been implemented.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There was evidence that positive behaviour support had improved significantly since the previous inspections. There were clear behaviour support plans, and evidence that incidents of behaviours of concern had reduced over the previous months.

Staff engaged by the inspectors could describe with confidence the steps they should take during any escalation of behaviours of concern. And one of the residents whose behaviour had previously had a significant impact on the wellbeing of others also told the inspector about their behaviour support plan in relation to one of their behaviours, and understood the reason for the expected boundaries.

However, the cyclical nature of the mental health of one of the residents meant that, whilst there had been few incidents of concern over the weeks prior to the inspection, the required actions agreed from previous inspections which had not been completed did not provide assurances that further issues would not arise should there be a deterioration in the resident's mental health in the future.

Judgment: Compliant

Regulation 9: Residents' rights

Overall the inspectors were not satisfied that residents were supported to have all of their rights met. Whilst some residents had been observed to have completely free choice of their supper, their rights to exercise choice in all elements of their daily lives was not evident.

Most residents remain either unoccupied during the evenings, some of them in their rooms with no occupation. There was no evidence of choice being offered to most of the residents in this area. For example, the resident who sat in front of the television all evening clearly had absolutely no interest in it.

During the course of the inspection, one of the inspectors detected a strong odour of urine in a resident's bedroom, and had to request a staff member to provide personal care. Incontinence wear which emanated significant personal odours was placed in the bin in the resident's bathroom, so that the odour remained in the room until it was removed. The inspector checked four times in the hour following the personal care delivery and found the incontinence wear had not been removed which left the resident in their bedroom with an unpleasant smell for over an hour.

As discussed earlier in this report, a resident who was in the process of transitioning to another centre was the date of their transfer, and staff could not provide that information. It was unclear if the plan has been finalised, or how much progress had been made, as no documented transition plan ws made available to the inspectors.

The records of residents meetings were reviewed by the inspectors, but these were found to be inconsistently held, and much of the information recorded as making up the discussion was repetitive on consecutive occasions.

Judgment: Not 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 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Avalon House OSV-0003694

Inspection ID: MON-0040306

Date of inspection: 28/06/2023

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The staff roster has been reviewed and changes made to the evening time roster.
An additional staff member is now rostered from 20:00hrs to 22:00hrs. The primary purpose of this role will be to support residents to engage in activities of their choice.The PIC will plan and schedule staff training to ensure there is always a registered nurse available to meet the healthcare needs of residents.

The outside cabin which is an interim space for one resident while an extension to the centre is being constructed to provide a self-contained apartment has been tidied, items stored in the space have been removed. The area is cleaned and ready for use.

The Registered Provider is working closely with HSE Estates. HSE Estates have requested the Fire Safety certification from the Local Planning Authority as a matter of priority.
Further information has being requested and submitted to the Local Planning Authority.
The Local Planning Authority Fire Officer has advised they need to carry out a final site visit prior to issuing a decision on the application for the fire safety certification.
No date has been identified for a site visit at this time, the PIC will continue to follow up with HSE Estates.
The cabin remains not in use at this time.
In the absence of this area, additional staff are rostered on duty to support the resident. This will enable the resident to engage in social activities of her choice such as holidays, day trips or to support personal time away from others as per their behavioral support plan.

The Provider is progressing the plans to construct the self-contained apartment for one resident in accordance with the application to vary the condition of registration. The Building contractor has submitted a schedule of works to the Person in Charge.

This schedule outlines a 24 week project for the construction of the self-contained apartment as previously described in the registration application submitted in April 2022. Building works have commenced on site since 08th August 2023. See attached Estates schedule of planned works.

The PIC has created an oversight template to be completed by each staff member assigned as a key worker for care planning. The template is required to be completed each month confirming reviews, updates and changes to care plans.

An in-depth review of each resident's daily schedule and activities care plan is being undertaken to ensure that each resident has daily opportunities for living a meaningful life.
Residents are supported by the Person in Charge and their keyworkers to develop daily activities schedules based on their will and preference and staff knowledge of their preferred activities. These have been completed and are available in their daily folders.
Two resident have sought not to have any activity schedules in places, however they have advised staff of their preferred activities and a list of these is available in their daily folders.
The healthcare assistants have been assigned to record the daily activities and social interactions of each resident in their daily folders.
The Person in Charge is monitoring this progress, through the use of the oversight document as outlined above.

All healthcare plans are being updated. Care plans will be audited by the PIC and PPIM to ensure they meet the present care needs of each resident

To ensure accuracy in documentation NMBI -Recording in Clinical Practice: Professional Guidance will be reviewed and discussed with all nursing staff and will be included as part of the one to one supervision appraisals for all nursing staff. Further refresher Medication Management training will be recompleted. The implementation of the effectiveness of the training in practice will be monitored as part of the supervision policy of the centre.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The staff roster has been reviewed and changes made to the evening time roster.
An additional staff member is now rostered from 20:00hrs to 22:00hrs. The primary purpose of this role will be to support residents to engage in activities of their choice.

An in-depth review of each resident's daily schedule and activities care plan is being undertaken to ensure that each resident has daily opportunities for living a meaningful life.

New Music Therapy care plans are being developed for all residents who choose to participate in music therapy, they will provide an outline of the benefits and objectives of the programme for each individual.

Further training sessions will be scheduled for all staff around person centered care, all staff will complete the Fundamentals of Advocacy training on HSEland.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: All storage areas which were overstocked and cluttered have been cleared and tidied to ensure best practice in line with IPC guidelines. The outside cabin which is an interim space for one resident while an extension to the centre is being constructed to provide a self-contained apartment has been tidied, items stored removed. The area is cleaned and ready for use. The Provider awaits the required fire safety certification from the local Planning Authority for the use of the outside cabin. A watertight, insulated storage unit has been requested to support in the storage needs of the unit. Work has commenced on the deep cleaning of all areas of the house. A full painting of the interior of the premises is planned to ensure it is maintained in a good state of decorative repair. Funding has been approved for the painting works to be completed. The Painter has advised that he can commence works on 28th August 2023. The completion of painting will require 15 working days, with no unforeseen complications. All windows are cleaned and a schedule for window cleaning has been implemented. The correct storage of the mop heads in use has been discussed at the most recent staff team meeting and the local IPC policy reviewed with all staff members.	
Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents: The transitional plan for one resident has been printed and is available to the resident and all staff. The plan is updated regularly and discussed with the resident. The transition plan is developed in a user friendly format with visual graphics to assist and aid understanding. A copy of the transition plan is kept by the resident in their bedroom. The transition plan outlines the following: How the resident was supported to make the decision to move to another designated centre. Various visits made to house to support with the decision making process. Involvement in choosing the décor for their room. Family representatives were involved to support the resident with their decision making process. Medical input from GP and consultants in relation to the use of oxygen therapy. The Register Provider has developed a local policy for the safe administration of oxygen	

by healthcare assistants, this will be supported by the candidate advanced nurse practitioner based in the service.

Additional training needs for supporting residents with epilepsy and oxygen administration have been identified, the staffing team in the new Designated centre have commenced additional training all staff will have this completed by 25th September.

The resident is visiting the new designated centre on regular basis and they have commenced decorating their new bedroom.

A final transition timeline has been agreed with the resident for the week commencing 25th September. The resident is happy with this and will continue to visit the new house regularly.

A copy of the transition plan is available on request.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Further refresher Medication Management training will be recompleted by the staff member. The implementation of the effectiveness of the training in practice will be monitored as part of the supervision policy of the centre.

NMBI -Recording in Clinical Practice: Professional Guidance will be reviewed and discussed with all nursing staff and will be included as part of the one to one supervision appraisals for all nursing staff.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC has created an oversight template to be completed by each staff member assigned as a key worker for care planning. The template is required to be completed each month confirming reviews, updates and changes to care plans to ensure they are meeting the current and on-going needs of each resident.

An in-depth review of each resident's daily schedule and activities care plan is being undertaken to ensure that each resident has daily opportunities for living a meaningful life in accordance with their preferred interest, will and preference.

Care plans will be a standing agenda item on staff team meetings for discussion to communicate updates on each resident's care plans in line with their assessed and changing needs.

The care plan for the individual whose needs have increased has had their care plan updated to reflect changes. Advice has been sought from professional bodies in the area of dementia and supporting information received and added to the plan of care. Further training and learning information for the staff team have also been requested through the NMPDU.

A concise one page plan, 'A day in my life' has been produced as a quick guide to support new staff coming into the service. This will be completed for all residents within the centre.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The PIC has created an oversight template to be completed by each staff member assigned as a key worker for care planning. The template is required to be completed each month confirming reviews, updates and changes to care plans to ensure they are meeting the current and on-going needs of each resident.

All healthcare plans are being updated. Care plans will be audited by the PIC and PPIM to ensure they meet the present care needs of each resident and they are sufficiently detailed to guide staff in their care interventions.

Advice has been sought from professional bodies in the area of dementia to support the updating of the care plan for one resident and further training and learning for the staff team have also been requested through Nursing Midwifery Planning &Development Unit.

A concise one page plan, 'A day in my life' has been produced as a quick guide to support new staff coming into the service to guide staff in meeting the complex medical needs of a resident. This will be completed as for all residents within the house.

The care plan for residents with a risk of skin intergity will be updated to guide staff on how to appropriatley monitor skin condtion and the individual interventions required in each case to mitigate any risk.

Recording in Clinical Practice: Professional Guidance will be reviewed and discussed with all nursing staff to ensure practice, accurately and professionally reflects the care given in documented records.
Further refresher Medication Management training will be recompleted by staff.

The care plan for a resident who sustained injuries following a fall has been further reviewed and updated to reflect the wishes of the resident requiring more time before they are confident to progress to the use of the mobility aid sourced.

A referral was made 04/08/2023 to the physiotherapist requesting a full review of the resident's mobility and the use of a mobility aid. This is scheduled for 23/08/23.

A social story has been developed for the resident in relation to the safe use of her mobility aid and supports required.

Person in charge has discussed the referral to the physiotherapist with the resident and the use of the mobility aid. The resident has advised the PIC that she knows how to use her aid and does not need staff to support her with it. She advised that she is sometimes nervous after having a shower.

The Residents mobility care plan and her personal care plan has been updated to reflect the supports required to ensure the residents safety during these times when the resident is nervous. The resident has agreed to meet with the physiotherapist for a review when the appointment date is confirmed.

Same is documented in the resident's personal notes.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The staff roster has been reviewed and changes made to the evening time roster.
An additional staff member is now rostered from 20:00hrs to 22:00hrs. The primary purpose of this role will be to support residents to engage in activites of their choice, that they have oppourtunity for meaningful enagagement and to ensure their psychosocial needs are supported.
The IPC policy has been reviewed and discussed with staff at the team meeting. Practice has been changed and all continence wear is now required to be disposed of to the clincal waste bins externally proivded.
The transition plan developed for one resident has been printed is now available for all staff. A copy of the transition plan is kept by the resident in their bedroom.
The frequency of residents' meeting has been reviewed to ensure they are taking placing on a weekly basis. The agenda will include the option for each resident to raise any wishes or concerns to ensure they are an open forum and a reflective consultation of the voice of the residents residing in the centre.
Each resident has a communication passport in place that reflects each residents communication needs.
Residents with verbal communication, can communication and participate at resident meeting on their own behalf.
Residents who communication through non verbal means are supported at residents meetings by the staffing team who are familiar with each persons communication methods and known preferences.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	29/09/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	17/10/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/10/2023

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.	Not Compliant	Orange	17/10/2023
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.	Not Compliant	Orange	21/07/2023
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other	Not Compliant	Orange	30/08/2023

	resident.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	15/09/2023
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.	Not Compliant	Orange	31/10/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	15/09/2023
Regulation 09(2)(a)	The registered provider shall ensure that each	Not Compliant	Orange	31/10/2023

	resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	25/07/2023