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:	Abode Doorway to Life CLG
Name of provider:	Abode Doorway to Life CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	29 August 2024
Centre ID:	OSV-0002411
Fieldwork ID:	MON-0044454

About the designated centre

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

This centre is part of a large-purpose built facility located on the outskirts of Cork City. Full-time residential and respite services are provided in this centre for a maximum of 10 residents, of both genders, from the age of 18 to 65 years.with physical and sensory disabilities There are ten individual resident bedroom provided while other rooms in the centre include offices, bathrooms, a residents' lounge and a dining area. Staff support to residents is provided by the person in charge, nursing staffing, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 29 August 2024	08:15hrs to 17:00hrs	Conor Dennehy	Lead
Thursday 29 August 2024	08:15hrs to 17:00hrs	Lisa Redmond	Support

What residents told us and what inspectors observed

The residents met during this inspection provided positive feedback on life and staff support in the centre. Residents left the centre at points during the day to attend day services, meet their personal assistants or to go to work and appointments. The centre where residents lived or availed of respite was seen to be well-presented on the day of inspection.

This designated centre was part of a larger building with some parts of the building, including a day service area and bedrooms used by tenants and for independent living, not part of the centre. Overall, the designated centre had 10 individual bedrooms for residents' use. This included six bedrooms that were used for full-time residential care while four other bedrooms were available to be used for respite. On the day of inspection two respite residents were availing of the centre along with six full-time residents. Of the eight residents that were present, seven of these were met by inspectors but on arrival at the centre, some residents were still in bed while three residents were having their breakfast in the communal dining room. Residents were observed laughing and smiling as they interacted with staff members and each other.

An inspector sat with residents in the dining room at this time, explaining why they were inspecting the designated centre. A number of residents were aware of the inspectors' role, and were happy to speak with inspectors about what it was like to live in the centre, or to access respite services there. One resident who had lived in the designated centre for a number of years told inspectors that they enjoyed living here. This resident worked locally, and was going to work on the day of the inspection. A second resident did not verbally express their view on what it was like to live in their home. However, throughout their interactions with staff members and other residents, they were observed laughing and smiling. Staff members working in the centre knew the resident well, and told the inspectors that this resident thought that it was very funny that inspectors from the Health Information and Quality Authority were in the designated centre.

Another resident showed both inspectors their bedroom. It was observed that the resident used their own fob to open their bedroom door independently. The resident's bedroom was seen to be to be personalised. For example, there was a framed and autographed Cork City jersey hanging on the wall. The bedroom had a call bell for the resident to call for assistance if they needed with the resident indicating that staff came when they used this. This resident spoke very positively of the support they received in the centre and highlighted how they were helped "to be as independent as possible". This was reiterated in the resident's personal plan, where they had told staff members "since moving to Abode, my experiences have been some of the best I have ever had. The independence I had previously lost I have regained and that is something I am happy about". When asked by inspectors, the resident said that they felt safe living in the centre and that staff and management were approachable. The resident also talked about attending a day

services elsewhere which they went to after speaking with inspectors.

All eight residents present on the day of inspection appeared to leave the centre during the day to attend day services, meet their personal assistants or to go to work and appointments. Some staff remained in the centre while day service attendees and tenants were also noted to be present on the grounds of the centre at times. The general atmosphere in the centre during the inspection was quiet and inspectors did not get many opportunities to observe or overheard staff and resident interactions but what was observed was respectful. However, residents did return to the centre as the inspection moved into the afternoon. One of these residents was a respite user who an inspector met in their bedroom. This resident told the inspector that they came for respite occasionally and that when arrived in the centre to start their respite stay, staff members did some checks with them first.

When asked if the resident got on with the staff, the resident indicated that they did and made numerous references to teasing the staff. The resident also said that if they had any problems they would go to the staff who were approachable. The inspector asked the resident if they liked coming to the centre for respite with the resident saying that they did. When asked what they liked about staying in the centre, the resident indicated the food and told the inspector that the centre's chef asked what food they wanted. The resident said that when staying in the centre, they did not usually go out which was what they wanted. The inspector asked if the resident could go out if they wanted with the resident responding by saying "I think so". After the discussion with the resident, the atmosphere remained quiet for the remainder of the inspection.

During walk-arounds of the centre, it was observed by inspectors that the premises provided was clean, well-presented and well-maintained. A number of residents living in the centre required a wheelchair to mobilise. Throughout the inspection, inspectors observed that the centre promoted accessibility, in line with the assessed needs of residents. For example, some resident bedrooms seen had ceiling hoists provided. Aside from bedrooms, rooms in the centre included offices, bathrooms, a laundry, a residents' lounge, a dining area and a kitchen. The kitchen operated as a commercial kitchen and so was not accessible to residents. This had been recognised as a restriction for residents so there was an accessible kitchenette within the residents' lounge. Despite its presence, inspectors were informed that residents did not use this kitchenette. Given its size, the centre did generally present as being homely although there was some closed-circuit television cameras present in the hall areas.

As inspectors were leaving the centre following a feedback meeting with the person in charge, they met one of the residents that an inspector had spoken with earlier in the day. This resident said that they had a question and asked how they could raise something with the Health Information and Quality Authority. One of the inspectors advised the resident to let staff know. The resident was also informed that a report of the inspection would be with centre management soon and that the resident could speak with the person in charge to discuss the inspection report. The resident seemed happy with this response and wished inspectors safe travel as they left the

centre.

In summary, from discussion with residents it was evident that residents were happy in the centre, and that they felt supported to live a life of their choosing. Residents spoken with were clear that they could raise any complaints and/or concerns to staff members working in the centre. It was also evident from speaking with residents that they felt safe.

The next two sections of the report 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

Evidence gathered during this inspection indicated that there was appropriate management and oversight of the centre. It was identified though that some required matters had not been appropriately notified.

Previous inspections of this centre in May 2019 and March 2022 had raised safeguarding and governance concerns amongst others. The latter inspection prompted the Chief Inspector of Social Services to issue a warning letter to the provider in the same month. Following that management changes were made for the centre and the provider overall which included the appointment of a new person in charge who remained in post. Subsequent inspections in November 2022 and August 2023 found improvement in compliance levels. Following the August 2023 inspection, the registration of the centre was renewed by the Chief Inspector until February 2027 with no restrictive conditions.

In August 2024 some notifications of a safeguarding nature were received from the centre. Given the nature of these, which had some similarities to other notifications received earlier in 2024 and in 2023, a decision was made to conduct the current inspection which was focused primarily on safeguarding. Overall, this inspection that there was appropriate management and oversight of the centre while no immediate safeguarding concerns were identified by inspectors. However, when reviewing records for staff in the centre, an inspector noted that issues of misconduct, while responded to by management of the centre, had not been notified to the Chief Inspector as required. Such records also indicated that there had been some negative dynamics between some staff working the centre. It was indicated that such dynamics had not impacted residents.

Regulation 14: Persons in charge

Based on documentation reviewed in advance of this inspection, the person in charge appointed for this centre had the necessary experience and qualifications as required by this regulation. During this inspection, the person in charge demonstrated a strong awareness of operations in the centre and of the residents living there. The person in charge ensured that all documents requested by inspectors were provided while also responding in a forthright manner to all other queries made. Based on staff rotas reviewed and the centre's statement of purpose, the person in charge worked full-time. The person in charge was responsible for this designated centre only.

Judgment: Compliant

Regulation 15: Staffing

Staffing in a centre must be in keeping with the needs of the residents and the centre's statement of purpose. The centre's statement of purpose had been reviewed in April 2024 and outlined the staffing in whole-time equivalents and the general staff levels by day and night. Such staffing arrangements were intended to meet the needs of residents availing of this centre with the staff team including nursing staffing, social care workers and care assistants. An inspector reviewed staff rotas from 24 June 2024 on and found that staffing was being provided in a manner consistent with the statement of purpose. Such rotas indicated that there was a core staff team in place but an inspector did note that eight different agency staff (staff sourced from an agency external to the provider) had worked in the centre in recent months. This had the potential to impact the continuity of staff support to residents but it was acknowledged that there were contributory factors behind such agency staff use.

The staff rotas in the centre were being maintained in a planned and actual manner. Aside from staff rotas, specific documentation must be obtained for all staff working in a designated centre (including agency staff). This documentation includes two written references, evidence of identity (including a recent photograph), full employment histories and evidence of Garda Síochána (police) vetting. During this inspection, an inspector reviewed a sample of staff files for staff employed directly by the provided and agency staff. For the former staff, the staff files reviewed found that most of the required documentation was present but some gaps were noted. For example, one staff file did not include evidence of identity while another did not a recent photograph and only had one written reference. The agency staff files reviewed also had most of the required documents but again there were some gaps. These included one staff with a large unexplained employment gap, another staff did not have an employment history provided nor proof of identity while no references were provided for two agency staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Records provided indicated that a supervision schedule was in place for 2024 and that the person in charge was ensuring that staff working in the centre received quarterly formal supervision or more often if required. An inspector reviewed a sample of supervision records for individual staff members and noted that topics including audits, goals, safeguarding, and training were being discussed with staff during these supervisions. A staff training matrix was provided for staff employed by the provider. This included 14 staff members with 13 of these having completed training in areas such as fire safety, behaviour support and safeguarding. One staff member though was not indicated as having completed training in some areas. Inspectors were informed that this staff member has newly hired and was not due to commence working in the centre until the week following this inspection.

Judgment: Compliant

Regulation 23: Governance and management

An organisational structure was in place for this centre that was outlined in the centre's statement of purpose. This structure provided for lines of accountability and reporting from front-line staff to the provider's board of directors. Included within this structure was the provider's Chief Executive Officer (CEO) whose office was based in the same building that the designated centre was part of. The CEO was present during the inspection and during discussions with them, they outlined how they engaged with the person in charge on a daily basis. This helped the CEO to be aware of the operations of the centre while the CEO outlined how the provider's board of directors would maintain oversight of the centre. This included the CEO providing the board with monthly reports while one member of the board also held a meeting with residents on a quarterly basis.

Other than monthly reports, an inspector was also informed by the CEO that reports of inspections by the Chief Inspector, annuals report and reports of unannounced visits would also be provided to the board. Conducting annual reviews and unannounced visits are specifically required by the regulations and are important in reviewing the quality and safety of care and support provided to residents in the centre. Since the August 2023 inspection, one annual review had been conducted by the person in charge with consisted of the relevant national standard and provided for consultation with residents. An unannounced visit for the centre was conducted on 18 January 2024. Under this regulation such visits must be conducted at least once every six month but the prior unannounced visit before January 2024 was done on 22 June 2023. This was a near seven month gap but following this inspection, the person in charge provided a draft report of another provider unannounced visit that had commenced on 18 June 2024.

As the report of the most recent provider unannounced visit had not been finalised,

an action plan for any issues identified during that visit was not completed. However, an action plan for the January 2024 provider unannounced visit was in place which indicated progress with issues identified during that visit. Action plans were also in place, where required, for various audits that that were conducted in the centre. Such audits covered areas such as cleaning, finances, restrictive practices, medicines and fire safety. A schedule was in place for each month setting out audits that were to be done on a given month. Documentation reviewed during this inspection indicated that audits were being carried out as scheduled. This provided assurances that there were systematic monitoring of the services and supports offered in the centre. Action plans arising from such audits indicated that identified areas for improvement were followed up on. This included during staff meetings.

Staff meetings were held every month however, there were different staffing grades present at these meetings. For example, meetings with all staff members were held on four occasions in 2024, while meetings with social care workers and nursing staff occurred on two occasions in 2024. In addition, there was also a quarterly meeting for those who were deemed 'shift leads' in the centre. It was also noted that relevant topics such as restrictive practices and infection prevention and control were discussed at these meetings. As such topics areas were also open to auditing, this indicated that developments and learnings were discussed with staff members through staff team meetings. It was also noted that the majority of staff members spoken with during this inspection were happy about the current management structures and processes in the centre.

Judgment: Compliant

Regulation 30: Volunteers

During the previous inspection in August 2023, it had been found that volunteers involved with the centre at that time did not have evidence of Garda vetting in place. On the current inspection, based on documentation reviewed, all volunteers involved with the centre had been Garda vetted and had their roles and responsibilities set out in writing. Arrangements had also been made to ensure that these volunteers received supervision and support with further documents reviewed confirming that these volunteers had received formal supervision from the person in charge during 2024.

Judgment: Compliant

Regulation 31: Notification of incidents

Under this regulation the Chief Inspector must be informed of particular events or

allegations that happen in a designated centre within a specific time period. Amongst the events that must be notified are allegations of misconduct by the provider or staff which must be notified within three working days. However, when an inspector was reviewing staff files, five matters from earlier in 2024 which constituted misconduct or alleged misconduct were identified. While these matters had been identified by the provider and responded to in keeping with their policies at the time they arose, they had not been notified to the Chief Inspector as required at the time of this inspection. Following the inspection, the Chief Inspector requested that all misconduct issues within a specific time period be submitted retrospectively with the person in charge acting on this request.

Judgment: Not compliant

Regulation 34: Complaints procedure

Information about the complaints procedure was on display in multiple locations around the centre. This outlined who residents could bring complaints to, who was the complaints officer and who complaints could be appealed to if required. A log of complaints was maintained in the centre which was reviewed by an inspector. This log contained two complaints that had been made in 2024 by residents and provided informed on the details of each complaint and how they had been followed up. While both complaints were marked as being resolved, one of the complaints did not indicate if the resident who had complained was satisfied with the outcome or not. This is something which is required by this regulation although it was seen that for the other complaint, the resident involved in that was recorded as being satisfied with the outcome.

Judgment: Substantially compliant

Quality and safety

No immediate safeguarding concerns were identified during this inspection. There was also evidence that residents' rights were being promoted in the centre.

Given the focus of the inspection, specific documentation relating to safeguarding matters were reviewed during this inspection. Such documentation indicated that any safeguarding matters reported or identified were being responded to appropriately. Safeguarding was being discussed with staff during team meetings and individual staff supervision. No immediate safeguarding concerns were identified during this inspection and staff spoken with demonstrated a good general safeguarding awareness. Residents spoken with also reported that they felt safe in the centre and did not highlight any safety concerns. Safeguarding was being

discussed with residents during regular resident meetings that took place in the centre. Such meetings were used to consult with residents and to give them information. This promoted residents' rights while residents were also being encouraged to be as independent as possible.

Regulation 28: Fire precautions

This regulation was not reviewed in full during the current inspection but the August 2023 inspection did identify that the first floor of the centre required review by a competent person to assess if some bedrooms were inner rooms. Following that inspection the provider indicated that such a review had taken place and that a recommendation to remove all electrical items from an area on the first floor had been completed. On the current inspection it was observed that there was no electrical items in this area while a fire safety assessment completed in April 2024 by a competent person indicated that there was good fire systems in the centre. Such fire safety systems were observed by inspectors during this inspection and included fire doors, emergency lighting and fire extinguishers while there were multiple unobstructed fire exits from both floors of the centre.

Records reviewed indicated that staff employed by the provider had completed fire safety training. The agency staff files reviewed on this inspection indicated that such staff had generally completed relevant training also but when initially reviewing the file for one agency staff member no documentary evidence of fire safety training was present. This was highlighted to the person in charge and later in the inspection a fire training cert of this agency staff member was provided. However, when reviewing the documents provided for a different agency staff member, no fire safety training cert was in place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

During the course of this inspection, the personal plans of three residents were reviewing (one full-time resident and two respite residents). From these the following was noted;

- For the full-time residential resident's personal plan, there was evidence of relevant comprehensive assessments being completed, a multidisciplinary review and a person centred-planning meeting taking place.
- This person-centred planning meeting had been used to identify goals for the resident to achieve. Such goals included going to Lourdes and documentation reviewed indicated that the full-time residential resident was being supported with this. For example, the resident had been given support to renew their

passport.

- The respite personal plans had relevant information to provide guidance on support respite residents during their stays. This included the provision of relevant medical reports.
- Respite residents' personal plans did not include documented goals for each resident's respite stay. For example, a number of residents chose to relax and rewind in the centre and from discussions with staff members it was evident that these wishes were supported. Others chose to access the local community independently or go to a neighbouring shopping centre to go shopping. However, it was difficult to determine from personal plans how these supports were provided to residents during their respite stays, and how these were evaluated to ensure the resident's satisfaction regarding the level and choice of activities provided, in line with their wishes.

Judgment: Substantially compliant

Regulation 8: Protection

Supervision and staff team meeting records read by inspectors during this inspection indicated that safeguarding was discussed with staff members. Further records reviewed indicated that staff working in the centre (including staff employed by the provider and agency staff) had completed safeguarding training. Staff members spoken with during this inspection demonstrated a good awareness about the safeguarding of residents and indicators of alleged abuse. No issues in reporting any concerns were raised by staff with inspectors. Staff were also aware of who to report any concerns to and were aware of the identity of the two designated officers for the centre. Designated officers are responsible for reviewing and responding to any safeguarding concerns as they arise. Posters were on display around the centre highlighting the assigned designated officers while also outlining how safeguarding concerns could be reported.

As mentioned earlier in this report, some notifications of a safeguarding nature were received from the centre during August 2024. The circumstances around these notifications were queried with management during this inspection. Documentation about these were also reviewed along with records relating to other previous safeguarding notifications. These indicated that safeguarding concerns reported and identified were being appropriately screened and referred to relevant statutory bodies. Where necessary, safeguarding plans were put in place in response to safeguarding concerns and there was documentary evidence that these were subject to review. Measures outlined in such safeguarding plan. For example, one safeguarding plan indicated that there was to be a review of a feedback process for respite residents with the person in charge outlining that some initial discussions around this had taken place.

Prior to this inspection, the person in charge had kept the Chief Inspector updated regarding the August 2024 safeguarding notifications. Investigations into two of

these had determined that there were no grounds for concerns but investigations for three others remained ongoing at the time of the inspection. While the outcome of these investigations remained to be determined, residents spoken with during this inspection indicated that they felt safe in the centre and highlighted no concerns around raising issues to staff members. It was also noted that safeguarding was a topic at regular resident meetings that took place. Notes of these were reviewed by an inspector which indicated that different safeguarding scenarios were discussed with residents. This provided assurances that residents were being assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for protection and self-care. Easy-to-read information related to safeguarding was available for residents in the centre if required.

Judgment: Compliant

Regulation 9: Residents' rights

During this inspection there was evidence that residents' rights were being promoted and protected in the centre. Examples of this included;

- One-to-one meetings between individual residents and their key-workers along with communal residents meetings were happening regularly. Such meetings were used to consult with residents and provide them with information regarding the operation of the designated centre, and issues affecting them.
- Residents were being encouraged to independently open their bedrooms through the use of fobs.
- Residents had access to call-bells in their bedrooms to call for assistance if required (one resident spoken with indicated that staff responded to these when used).
- Adapted cutlery being provided to residents to support their independence when eating.
- The provision of an accessible kitchenette for residents to provide with some facilities to prepare and cook their meals if they wished to do so.
- The wishes of one resident not to have certain information contained in their personal plan were respected.
- Residents' daily notes were written in a respectful manner, referencing the supports provided to residents to achieve their health and personal goals.

Such matters indicated that the promotion of rights and independence was being emphasised in the centre. Staff spoken with were aware of how to promote these with records reviewed indicating that staff employed directly by the provider had completed training in human rights.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Abode Doorway to Life CLG OSV-0002411

Inspection ID: MON-0044454

Date of inspection: 29/08/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Requests for familiar agency staff when needed are being made. Due to the nature of last-minute requirements and not a pre- planned need for agency staff this cannot always be facilitated. All internal staff files have missing/ outdated elements updated/ included. PIC has put a new system in place for obtaining and maintaining agency staff files. All required information is now requested ahead of the agency staff's shift and maintained in a central file on site by the PIC.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All retrospective NF07's have been notified to the chief inspector for the time period requested. PIC will report any new allegations of misconduct by the provider or staff.	

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Missing resident feedback was completed following the identification of this gap in the closing of this complaint. Complaints officers reminded of process of feedback from residents following closure of complaints.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: PIC has put a new system in place for obtaining and maintaining agency staff files. All agency fire certificates are now requested before the agency staff's shift and maintained in a central file on site by the PIC.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: A process for discussing and recording Respite users' goals while in service will be developed. Feedback on this will be supported as part of the existing feedback process in place for all respite users before they leave the center.	

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(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	11/09/2024
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	11/09/2024
Regulation 31(1)(g)	The person in charge shall give	Not Compliant	Orange	03/09/2024

	the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	11/09/2024
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/09/2024