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:	Florence House
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	02 July 2024
Centre ID:	OSV-0002632
Fieldwork ID:	MON-0041293

About the designated centre

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

Florence House is a designated centre operated by the Health Service Executive (HSE). The designated centre provides a community residential service for up to eight adults with a disability. The centre is a detached two storey house set on its own grounds in a housing estate on the outskirts of a large town in County Wexford. It is located within a short distance of local facilities and amenities. The building consists of two floors, with the ground floor being accessible to residents and the upstairs floor used for office purposes. The centre's downstairs comprises of a sitting room, activity room, sensory room, dining room, kitchen, eight individual resident bedrooms, visitor room, laundry room, two shared bathrooms and two offices. There was a garden for residents to avail of if they wished. The staff team consists of a Clinical Nurse Manager (CNM) 1, staff nurses and multi-task workers. The staff team are supported by the person in charge.

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
Tuesday 2 July 2024	09:15hrs to 18:30hrs	Conan O'Hara	Lead
Tuesday 2 July 2024	09:15hrs to 18:30hrs	Tanya Brady	Support

What residents told us and what inspectors observed

This unannounced inspection was completed to follow up on progress against the registered provider's stated actions and to provide assurance that safe and good quality care was being provided to residents in this centre. This inspection was completed by two inspectors over one day.

Overall the findings of this inspection indicated that some actions had been addressed to improve residents' living environment. However many of the issues that were identified in July 2023 and previously, remained a concern.

The inspectors found that residents had their personal care and medical needs well managed and that the provider had taken steps to improve the centre premises. However, inspectors found that there remained a significant level of non-compliance in the centre. The concerns regarding how the provider was meeting social needs of the large resident group with high support needs had not been addressed. For example, the provider had outlined in plans submitted to the Chief Inspector of Social Services, that two new premises would be ready to support residents needs. Inspectors were now informed that the planned time lines could not be achieved. The inspectors acknowledge that there were delays with the planning process and the provider was responding to and managing other priorities in their overall services. However, the inspectors found that as a result the residents, in this centre, continued to be adversely effected in terms of having meaningful social engagement and a good quality of life.

The inspectors had the opportunity to meet with all eight residents who live in this house over the course of the inspection. All residents had complex communication skills. All residents used different methods of communication, such as vocalisations, facial expressions, behaviours and gestures. The inspectors spent time over the course of the inspection engaging with residents and staff, observing care practices, in discussions with the staff and management team, observing daily routines and the activities in the centre as well as reviewing documentation.

On arrival, the inspectors observed two residents having breakfast while other residents were being supported with personal care and others were in the living room. Throughout the morning residents were supported to have breakfast and spend time in the sitting room, kitchen or sensory room. Later in the morning, three residents were observed leaving the centre for a drive. In the afternoon, following lunch the majority of residents remained in the centre either in the kitchen, sitting room or in their rooms with periods of time spent on personal care.

Inspectors found that there was sufficient staff in place to complete personal and health related care. The complex physical and medical needs of residents left staff with limited time for social and activity based engagement. The eight residents in this service did not attend any formalised day services or work during the day and are reliant on the staff team for activation. While, staff interactions were observed

to be caring and kind with residents, the inspectors observed residents spending long periods inside their home with minimal engagement with others. For example, one resident was given preferred objects (plastic blocks) to explore after their breakfast and this exploratory activity was not changed, after lunch the resident moved to another room still with the same objects. Other residents were placed in rooms with an activity such as the television on or the sensory lights on and they remained there for long periods without staff engagement. Inspectors observed, for example, if residents were in front of the television that limited consideration was given to the programming and whether it was of interest to individuals.

The inspectors did observe staff completing activities at designated times such as resident observation of mealtime preparation. However, these activities were not individual and involved residents in a row observing food preparation. Inspectors acknowledge that staff had endeavoured to provide an activity that was sensory in nature and that they could deliver within the resources available to them. The residents who engaged in this did appear to enjoy smelling and exploring the foods being used in the meal. However this was found to be very basic in terms of the provision of social activation and stimulation.

In addition, the inspectors observed multiple examples of 'task orientated' and 'institutionalised' care over the course of the day which negatively impacted on the homeliness of the centre including:

- maintenance coming/going from the centre and picture frames being hung using power tools before nine o clock in the morning which created significant noise before a number of residents were out of bed,
- breakfast cereal being collectively poured into bowls lined up in the kitchen while residents were still in their bedrooms, and
- members of the staff team wearing scrubs in the residents home.

The inspectors also reviewed feedback from residents representatives regarding the care and support provided in the centre. For example, in six satisfaction surveys completed by the residents' representatives they noted that too many people were living in the centre together and that there was too high a turnover of staff.

In summary, the inspectors found that the centre was meeting the medical and personal care of residents. However, the social care needs and quality of life outcomes of residents remained unmet. This has been identified as an area for improvement in this centre since 2020. While acknowledging the provider is managing a number of services with competing priorities, at the time of the inspection, the long-standing concerns of meeting the health and social care needs of the residents living in this centre remain unaddressed.

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

Capacity and capability

The previous inspection of this designated centre in July 2023 found that significant improvement was required to come into compliance with a number of Regulations. The Regulations included governance and management, residents' rights, positive behaviour support, fire safety, premises and staff training and development. Some of these areas for improvement had also been identified in previous inspections.

Following the previous inspection, a cautionary meeting was held with the provider regarding the continuing non-compliance with key Regulations and the prolonged period of time it was taking to address provider set actions. Following this meeting, the Health Service Executive submitted formal assurances to the Chief Inspector, outlining their proposed actions to improve the standards of care and support in the centre and come into compliance with the Health Act.

There remained high levels of non-compliance in this centre which negatively impacted on the quality of life of residents. The inspectors found that the provider had not completed all actions they had identified nor had changes been implemented to enhance the lived experience of residents on a day-to-day basis other than some premises updates. Residents continued to spend long periods of time in their home with limited opportunities for social activation or engagement. Residents access to transport options to support them in leaving their home remains limited. The provision of core and stable staffing and local management teams are still not in place in this centre.

Improvements were required in the governance arrangements of the centre to ensure that areas for improvement were addressed in a timely manner and the service provided to residents was in line with their assessed social needs. For example, areas identified for improvement on this inspection have been previously identified over a number of years and minimal actions have been made to allow the centre come into compliance with the Regulations. These areas include the supervision arrangements, fire safety, compatibility of the resident group and availability of transport.

Regulation 15: Staffing

The provider had not ensured a consistent staff team was in place in the designated centre. At the time of the inspection the centre was operating with 5 whole time equivalent vacancies or staff on approved leave. The staffing complement was being maintained through the existing staff team and the use of relief and agency staff.

The person in charge had both planned and actual staffing rosters in place. The inspectors reviewed a sample of the roster and were concerned with the numbers and consistency of staffing provision in this centre. From a review of the roster, the

inspectors found that there was a high reliance on agency staffing to maintain the staffing complement. There was evidence of efforts to increase the consistency of staffing by identifying key agency staff to provide long-term cover for the vacancies, however this remained a challenge for the provider. On the day of inspection eight staff were rostered for duty but one was unavailable at short notice. Seven staff were on duty over the course of the day - three of which were agency staff.

At night, three waking-night staff were in place to support the eight residents. However, at times the third staff at night was recorded as having been redeployed to other services.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had systems in place for the training and development of the core staff team. From a review of a sample of training records, it was evident that the core staff team in the centre had up-to-date training in areas including safeguarding, fire safety and de-escalation and intervention techniques. In contrast while the provider had 'terms of engagement' with the various agencies providing agency staff to the centre regarding the requirement for them to have mandatory training, it was not clear if the agency staff had the specific training in line with the residents needs including feeding, eating and drinking. This had not been followed up by the provider and was of concern, in particular, due to the numbers of agency staff, the complex nature of the residents in the centre and the particular skills required by the staff who supported them to ensure resident safety.

While all of the staff team engaged in supervision meetings the opportunity for them to engage on a regular basis had been impacted by multiple changes in the management team as outlined under Regulation 23. The inspectors reviewed a sample of supervision files and found that not all supervision meetings were held in intervals of six months which was the minimum as outlined in the providers supervision policy. A schedule was in place for the upcoming year. The provision of supervision had also been identified as an area for improvement at the last inspection and lack of support for staff to ensure they perform their duties to the best of their ability remains an area of concern.

Judgment: Not compliant

Regulation 23: Governance and management

The previous inspection of this centre had identified that the provider's oversight arrangements did not effectively address areas for improvement. Areas that had

been identified as required to ensure residents' had a service that was appropriate to their assessed needs were still not in place.

There was, on the day of inspection, a clearly defined management structure in place. However, the governance arrangements required review to ensure they were effective. Since July 2023 there had been four changes to the person in charge role, this had not allowed for any identified actions within the centre to be effectively or efficiently managed. At the time of the inspection, the current person in charge was employed on a full-time basis through an agency and it was unclear whether this was a time limited position. They were found to be suitably qualified and experienced. The person in charge was newly in post and on the day of inspection stated that they required time to become familiar with the residents' needs and with individual health and social care needs.

The frequent changes to the local management team had resulted in gaps in oversight and periods of instability within the centre which was a challenge for the staff team and the provider in ensuring clear communication systems were in place and that actions were completed in a timely manner.

As previously noted a cautionary meeting was held in July 2023 following the previous inspection which found a number of areas of non compliance, some of which had been previously identified and remained not completed at that point. In response, the provider submitted a detailed assurance plan outlining how they would address the areas of concern. The findings of this inspection found that a number of actions had not been effectively completed. This included supervision arrangements for the staff team, the assessment of compatibility within the resident group, meeting individuals social needs to enhance the quality of their life and fire safety arrangements.

Improvements remained required in ensuring that the centre is appropriately resourced. The previous inspection found for example, that the arrangements for the centre's transport required review. This had not been addressed. The provider outlined in their compliance plan response that an appropriate vehicle would be sourced by December 2023. While the inspectors were informed an appropriate vehicle was purchased it was still not available on the day of inspection. On the day of the inspection, the centre had access to two vehicles as previously. Each vehicle could only support a limited number of wheelchair users at one time. Of most impact the wheelchair lift for one vehicle was broken and had been for a number of weeks. This resulted in only one vehicle being available for use by residents who used wheelchairs. For this example transport arrangements, these continue to require improvement as this negatively impacted on the choice and control of residents in the centre and their ability to go out.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed a sample of adverse accidents and incidents occurring in the centre and found that the Office of the Chief Inspector was notified as required by Regulation 31.

Judgment: Compliant

Quality and safety

There remained concerns in relation to the quality of services being delivered to residents impacting on the quality of their lives. This was also identified in previous inspections. Inspectors found that there remain gaps in the recognition, identification and provision of care and support that related to the quality of residents' lives. Inspectors found that while some provider's systems were identifying areas that required action, the timeliness of response to these actions was poor.

Overall, inspectors found that residents were being well supported in the areas of personal and health-care. However, significant improvements were required in promoting and protecting residents' rights and their social opportunities and quality of life. In addition, improvement was required in fire safety and positive behavioural support.

The previous inspection found that the numbers of and compatibility of the resident group negatively impacted on the ability to effectively implement recommended behavioural interventions and to provide an engaged and socially fulfilled life for residents. These remained areas for improvement. The lack of resources directly contributed to a lack of personalised daily activities and person centred care.

The provider had provided a written action plan to the Chief Inspector following the cautionary meeting held in July 2023. In this the provider outlined plans to reduce the number of residents. At the time of this inspection, this remained an area which required significant improvement. The provider had for example developed an environmental compatibility assessment tool to inform the transition of residents. Only one assessment had been started at the time of the inspection.

Regulation 13: General welfare and development

Inspectors found that significant improvements were required in the general welfare and development arrangements in place to support residents with access to facilities for occupation and recreation and opportunities to participate in activities in line with their interests and needs.

The eight residents did not attend a formal day service or work during the day and are reliant on the staff team for activation. However, on the day of the inspection, residents were observed spending long periods of time without meaningful engagement. One resident for example was on their own in the centre sensory room with their back to the door. Inspectors observed that the resident was at least 90 minutes in the room with minimal staff engagement, when one inspector and the person in charge entered the room the resident was observed to require personal support to manage nasal secretions that had not been previously observed or attended to. The staff team were observed trying to provide some engagement however,due to significant demands on staff in particular staff who were not core staff and less familiar with residents inspectors observed that health and personal care tasks were prioritised. Social engagement when observed was provided to small groups of individuals or for brief periods of time.

Inspectors read staff meeting minutes for example those from May 2024 where a stated action was to ensure the residents engaged in something meaningful twice a week. The inspectors reviewed samples of activity records, staff handover notes, and daily activation and goal records which demonstrated that significant improvement was required for residents to engage in activities in the centre and in their communities. For instance in a two week period one resident had only left the centre on a few occasions and each of these was for a drive. Another resident in the same time frame was noted to leave their home less frequently, i.e, for for three drives and two walks. The inspectors observed residents spending long periods inside their home with minimal engagement with others. This was also reflected in documentation noting residents spending vast amounts of time without any stimulation.

Inspectors found that while goals were set for residents, and recorded in their personal files, there was limited evidence of how these were being prioritised or fulfilled. One resident had no progress notes completed since June 2023 and another resident had not had an annual review of their personal plan since December 2021. Activation schedules that had been completed for residents were identical in all eight resident files with no evidence that these were personalised, based on consultation or considered individual preferences, likes or wishes.

Judgment: Not compliant

Regulation 17: Premises

The designated centre is a large purpose built premises located in a residential area on the outskirts of a town in Co Wexford. The centre is spread over two floors, with the ground floor being the residents home and the upstairs floor used for office purposes. There is a garden area to the rear of the home which is hard surfaced and ample parking to the front and side.

The inspectors completed a walk-through of the premises of the designated centre

accompanied by the person in charge and CNM1. The previous inspection identified a number of long standing areas for improvement including damaged flooring and areas with chipped and damaged paint. These had been addressed and inspectors observed new flooring installed in areas of the centre and the internal areas painting. The provider had scheduled for decorative items to be replaced and the covering of areas of pipe work that were visible. However, there remained further areas for improvement in the premises. For example, addressing the worn flooring in the laundry room, decorating of the dining room following painting and reviewing areas of laminate peeling from kitchen presses.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The systems in place for fire safety management, particularly in the area of fire evacuation drills, required improvement. This had been identified as an area for improvement on the previous inspection.

While there was evidence of regular fire drills both 'day' and 'night' the 'night-time' fire drills reviewed had not included the minimum number of staff and highest number of residents. This meant that it was not demonstrable that the arrangements in place at night-time were appropriate to evacuate all persons with the minimal numbers of staff from the designated centre in a timely manner. One resident had not in fact been present for any of the centre fire drills since January 2024.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a personal evacuation plan in place which appropriately guided staff in supporting residents to evacuate.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Some residents in this centre were identified as requiring supported to manage their behaviours. The previous inspection found that the effective implementation of some recommended interventions was not always possible in the centre due to the group profile of the residents' needs. The inspectors found that this had not been effectively addressed and remained an area for improvement.

Where required positive behaviour support guidelines were in place with a quick

guide summary available for staff to reference. Residents were supported to access psychology and psychiatry as required. Inspectors spoke to the provider's advance nurse practitioner in behaviour support and to the staff team and inspectors were told that there were challenges in implementing guidance due to the number and needs of the group of residents. This was in particular the case where residents required a low arousal approach or required low stimulus environments for example in specific activities such as mealtimes. In addition it was identified that some residents required enhanced activation or needed to leave their home as part of their needs. Plans reviewed by inspectors noted that this was difficult to achieve due to the number of residents with complex needs.

There were systems in place to identify, manage and review the use of restrictive practices. However, inspectors found that not all restrictive practices in use in the designated centre had been appropriately identified, assessed and reviewed and this was also the position at the last inspection. The previous inspection found that improvement was required in reviewing night-time welfare checks which were in place for all residents. While there was evidence that the provider had completed an assessment for each resident for the night-time welfare checks and in some cases reduced the number of checks, the rationale for the welfare checks were not clearly detailed in the assessment and required further review.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents living in the centre had high care needs and at times, it appeared that the mix of residents in the centre contributed heavily to the lack of personalised daily activities and person centred care.

Residents' choice and control in their daily lives were limited at times due to daily schedules. This is a long standing issue which had been identified on previous inspections and self-identified by the provider in internal reviews. However no appropriate level of corrective action ha been taken.

In response to the findings of the previous inspection and cautionary meeting held in July 2023, the provider had provided a written action plan to the Chief Inspector which outlined plans to reduce the number of residents. At the time of this inspection, this remained an area which required significant improvement as this action had not been achieved within the provider's time line and it remained unclear when it would achieved.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Florence House OSV-0002632

Inspection ID: MON-0041293

Date of inspection: 02/07/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider has reviewed the roster and made changes to reflect the dynamics within the Centre providing defined roles and responsibilities in some of the MTA lines. There are 21.4 Whole Time Equivalent (WTE) posts assigned to Florence House, on the day of Inspection there were 4 WTE vacant Multi-Task Attendant (MTA) posts – 2 of these were being covered by long-term agency staff and 2 by irregular agency. There were also 2 staff nurses on long term sick leave presently. Of the 2 MTA posts being covered by long-term agency, one of these will be filled by a permanent member of staff from 16/09/2024. The 2 lines being covered by irregular agency have been revised and one will be a dedicated cleaning line from 16/09/2024 and the hours from the 2nd vacant post have been reconfigured to include late evening finishes twice weekly and this line will be specifically to support resident access and attend events/engagements of their choosing in line with their will and preference and also to progress and achieve their identified goals as part of their weekly schedule. In relation to the 2 staff nurse absences, the registered provider is currently recruiting the 2024 nursing graduates with a plan to assign one person to the Centre on a fixed line. The 2nd nursing post will continue to be covered by service locum nurses. The Provider will review the Statement of Purpose and complete a risk assessment for the occasional occurrences when the 2nd MTA on night duty may be redeployed at night in the event there is an emergency admission to hospital or short notice sick leave for night duty in another centre.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

The Registered Provider has engaged with both agency service providers used by the service. The Provider has provided both agencies with a list of mandatory training that all staff covering shifts in the service are required to have, this includes the International Dysphagia Diet Standardisation Initiative training available on HSELand. Both agencies have agreed to this request and have committed to all staff taking shifts in the service will have completed the International Dysphagia Diet Standardisation Initiative training by 28/09/2024. Both agencies have also agreed to provide training status of all staff on the 28/09/2024 and then every 3 months following this date.

The Person in Charge has reviewed the staff training matrix to ensure enhanced oversight and support monitoring of compliance.

The Person in Charge has reviewed the supervision schedule in place and will schedule any supervision meetings outstanding to ensure all staff receive the required supervision as per service Supervision Policy.

Performance Achievement engagement is mandatory for all staff employed by the HSE, this involves a scheduled meeting with the PIC and offers staff the opportunity to engage with the PIC and address any additional training or supports required. Between formal supervision and mandatory performance achievement this provides all staff with a minimal of 3 formal meetings annually with the PIC, and there may be additional meetings scheduled if and when required by staff.

The PPIM will carry out monthly supervision with the PIC for a period of 4 months after which time it will be reviewed to offer support and ensure oversight, progression and completion of the Centre's compliance plan.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider has established a governance and oversight team, chaired by the Head of Service with terms of reference agreed to ensure the residents experience a good quality of life and specifically address the issues raised in the inspection report.

The team are meeting weekly initially for 6 weeks after which the frequency of these meetings will be reviewed with a further review of frequency in 6 months. These meetings commenced on 12th August 2024.

The registered provider has appointed a full time suitably qualified and experienced CNM2/PIC in order to provide stability and consistency for the centre. There is also a full time experienced senior CNM1 on the staff team.

The PPIM will carry out monthly supervision with the PIC for a period of 4 months after which time it will be reviewed to offer support and ensure oversight, progression and completion of the Centre's compliance plan.

The Person in Charge has reviewed the supervision schedule in place and will schedule any supervision meetings outstanding to ensure all Staff receive required supervision as

per service Supervision Policy.

The CNM2/PIC and CNM1 will engage in the HSE Professional Development Planning process for nurses which facilitates nurses to use their experience and skills to identify their professional goals and the supports required to achieve their goals helping to advance both their individual plans and service user needs.

The CNM2/PIC and CNM1 will ensure that all Multi-Task Attendants engage in the HSE Performance Achievement process which is mandatory for all employees in the HSE.

In the absence of a national standard compatibility assessment, the service has developed their own Compatibility Assessment which is completed with the known will and preference of residents and their known likes and dislikes as recorded in their Individual Care Plans. The PIC will review the completed assessments. The PPIM presently sits on a National Expert Advisory Group that are developing a national Compatibility Risk Assessment and she will continue to provide feedback and share learning.

The Resident's Weekly Meeting has been reviewed and amended to incorporate the principles of Social Role Valorisation (SRV). The new format identifies scheduled appointments for any residents during the week and how each resident's will and preference for events of their choosing will be facilitated. A 09.00-17.00 hrs. Monday to Friday support line has been changed to include late finishes i.e. 22.00hrs twice weekly to support residents to access events/engagements they wish to attend in the evenings.

A 2nd vehicle was acquired in December 2023 that accommodated up to 3 wheelchair users, staff have also been advised that there are additional vehicles available in the afternoons, evenings and weekends from Day Services and these can be utilised as required and especially if one of the regular vehicles is in the garage for repairs. The option of wheelchair taxis are also available to staff if required and the service will cover this cost.

The registered provider has completed a review of the day to day delegation of duties with changes to the Centre's roster to ensure there will be a dedicated cleaning line which will ensure resident's scheduled events/activities are not impacted. Each staff will be assigned a specific resident daily for whom they will be responsible for supporting the resident to access the community daily, partake in any scheduled events/appointments, support the resident with progression and achieving identified goals, engaging the resident in meaningful activities also within the home and for documenting and recording progress.

The PPIM will carry out quarterly audit inspections incorporating the PIC's audits carried out over the preceding 3 months to ensure all actions from last quarters review have been completed and closed off appropriately.

An action monitoring log will be developed to monitor actions from audits and inspections with a system to identify time sensitive priorities.

The registered provider has engaged with HSE Day Service, (Project Manager for New

Directions) to support and augment the implementation of Person-Centred Planning (PCP) training within the centre. This training will assist with making informed choices, supporting goal setting and planning for the future with the residents.

The Register Provider has liaised with the lead in the National Decongregation Office with a plan to provide training on Social Role Valorisation for staff.

In relation to fire safety: a fire drill has been scheduled for 22/08/2024 to simulate a night-time fire evacuation, whereby all residents will be present in their bedrooms and only 2 staff will carry out the evacuation. The outcome and learning from this will contribute to a risk assessment being developed to identify the risks and control measures required in the event the 3rd staff on night duty has been redeployed.

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 registered provider has commenced the planned transition of one resident to another centre. This will reduce the number of residents in this centre to 7 from 01/09/2024. The room vacated by the resident will be repurposed to a storage room for resident's appliances and aids. This will ensure the relaxation room will be used for its intended purpose to ensure recommendations referenced in Behaviour Support Plans can be actioned using a low stimulus / low arousal space.

The registered provider has completed a review of the day to day delegation of duties with changes to the Centre's roster to ensure there will be a dedicated cleaning line which will ensure resident's scheduled events/activities are not impacted. Each staff will be assigned a specific resident daily for whom they will be responsible for supporting the resident to access the community daily, partake in any scheduled events/appointments, support the resident with progression and achieving identified goals, engaging the resident in meaningful activities also within the home and for documenting and recording progress.

The registered provider has engaged with HSE Day Service, (Project Manager for New Directions) to support and augment the implementation of Person-Centred Planning (PCP) training within WRIDS. This training will assist with making informed choices, supporting goal setting and planning for the future with the residents.

The Resident's Weekly Meeting has been reviewed and amended to incorporate the principles of Social Role Valorisation (SRV). The new format identifies scheduled appointments for any residents during the week and how each resident's will and preference for events of their choosing will be facilitated. A 09.00-17.00hrs Monday to Friday support line has been changed to include late finishes i.e. 22.00hrs twice weekly to support residents to access events/engagements they wish to attend in the evenings.

The approach to the allocation of staff has been reviewed in conjunction with the roster review to support and embed the SRV approach into practice. The registered provider

will ensure the minutes of these weekly meetings and plans will be audited by the Day Services CNM2 monthly.
As a support the HSE Day Service Opportunities Officer will liaise with the Day Service CNM2 on a quarterly basis for a 12 month period. The purpose of these quarterly meetings is to review the facilitation of a meaningful day for the residents of Florence House.

The Annual Review for 2024 for the identified resident has been scheduled. All other Annual Reviews for 2024 have been completed.

Resident's goals will be reviewed by the keyworkers / associate keyworker monthly, ensuring an SRV focus on goal setting, progress and review.

A 2nd vehicle was acquired in December 2023 that accommodated up to 3 wheelchair users, staff have also been advised that there are additional vehicles available in the afternoons, evenings and weekends from Day Services and they should be utilized as required and especially if one of the regular vehicles is in the garage for repairs. The option of wheelchair taxis are also available to staff if required and the service will cover this cost.

The registered provider has engaged with HSE Day Service, (Project Manager for New Directions) to support and augment the implementation of Person-Centred Planning (PCP) training within WRIDS. This training will assist with making informed choices, supporting goal setting and planning for the future with the residents.

The Register Provider has liaised with the lead in the National Decongregation Office with a plan to provide training on Social Role Valorisation for staff.

The Registered Provider has ensured Assisted Decision Making (ADM) / Consent information and training has being provided to staff by:
• members of the Assisted Decision Making team through 2 recent workshops
• mandatory HSE training on the National Consent Policy on HSELand
• releasing staff to attend webinars in relation to Assisted Decision Making.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider will ensure the flooring in the laundry room is replaced by the contractor.

Maintenance have reviewed the kitchen cabinets and a plan is in place to rectify damaged cabinet fronts.

The PIC has a plan devised to complete the decoration of the dining room following recent painting.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A Fire drill has been scheduled for 22/08/2024 to simulate a night-time fire evacuation,

whereby all residents will be present in their bedrooms and only 2 staff will carry out the evacuation. The outcome and learning from this will contribute to a risk assessment being developed to identify the risks and control measures required in the event the 3rd staff on night duty has been redeployed.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The registered provider has commenced the planned transition of one resident to another centre. This will reduce the number of residents in this centre to 7 from 01/09/2024. The room vacated by the resident will be repurposed to a storage room for resident's appliances and aids. This will ensure the relaxation room will be used for its intended purpose to ensure recommendations referenced in Behaviour Support Plans can be actioned utilising a low stimulus / low arousal space.

In the absence of a national standard compatibility assessment, the service has developed their own Compatibility Assessment which is completed with the known will and preference of residents and their known likes and dislikes as recorded in their Individual Care Plans. The PIC will review the completed assessments. The PPIM presently sits on a National Expert Advisory Group that are developing a national Compatibility Risk Assessment and she will continue to provide feedback and share learning.

The Resident's Weekly Meeting has been reviewed and amended to incorporate the principles of Social Role Valorisation (SRV). The new format identifies scheduled appointments for any residents during the week and how each resident's will and preference for events of their choosing will be facilitated. A 09.00-17.00 hrs. Monday to Friday support line has been changed to include late finishes i.e. 22.00hrs twice weekly to support residents to access events/engagements they wish to attend in the evenings.

The registered provider has ensured all residents have had a review of their night welfare checks and have removed night welfare checks for 6 residents and reviewed the frequency of checks for 2 residents based on each resident's individual needs and requirements. The resident's individual night-time support plans and risk assessments will be reviewed as required and with consideration for the residents' wishes.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
In the absence of a national standard compatibility assessment, the service has developed their own Compatibility Assessment which is completed with the known will and preference of residents and their known likes and dislikes as recorded in their Individual Care Plans. The PIC will review the completed assessments. The PPIM presently sits on a National Expert Advisory Group that are developing a national Compatibility Risk Assessment and she will continue to provide feedback and share learning. The findings will inform future decongregation planning.

The registered provider has commenced the planned transition of one resident to another centre. This will reduce the number of residents in this centre to 7 from

01/09/2024. The room vacated by the resident will be repurposed to a storage room for resident's appliances and aids. This will ensure the relaxation room will be used for its intended purpose to ensure recommendations referenced in Behaviour Support Plans can be actioned utilized using a low stimulus / low arousal space.

The Resident's Weekly Meeting has been reviewed and amended to incorporate the principles of Social Role Valorisation (SRV). The new format identifies scheduled appointments for any residents during the week and how each resident's will and preference for events of their choosing will be facilitated. A 09.00-17.00 hrs. Monday to Friday support line has been changed to include late finishes i.e. 22.00hrs twice weekly to support residents to access events/engagements they wish to attend in the evenings.

The approach to the allocation of staff has been reviewed in conjunction with the roster review to support and embed the SRV approach into practice. The registered provider will ensure the minutes of these weekly meetings and plans will be audited by the Day Services CNM2 monthly.
As a support the HSE Day Service Opportunities Officer will liaise with the Day Service CNM2 on a quarterly basis for a 12 month period. The purpose of these quarterly meetings is to review the facilitation of a meaningful day for the residents of Florence House.

The registered provider has ensured all residents have had a review of their night welfare checks. The resident's individual night-time support plans and risk assessments will be reviewed as required and with consideration for the residents' wishes.

The registered provider has engaged with HSE Day Service, (Project Manager for New Directions) to support and augment the implementation of Person-Centred Planning (PCP) training within WRIDS. This training will assist with making informed choices, supporting goal setting and planning for the future with the residents.

The Register Provider has liaised with the lead in the National Decongregation Office with a plan to provide training on Social Role Valorisation for staff.

The Registered Provider has ensured Assisted Decision Making (ADM) / Consent information and training has being provided to staff by:
• members of the Assisted Decision Making team through 2 recent workshops
• mandatory HSE training on the National Consent Policy on HSELand
• releasing staff to attend webinars in relation to Assisted Decision Making.

Resident's goals will be reviewed by the keyworkers / associate keyworker monthly, ensuring an SRV focus on goal setting, progress and review.

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	02/09/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/10/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	31/10/2024

	as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	19/10/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/10/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2024
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	31/10/2024
Regulation 28(3)(d)	The registered provider shall	Not Compliant	Orange	30/08/2024

	make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/08/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where 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.	Not Compliant	Orange	02/09/2024
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	Not Compliant	Orange	30/09/2024

	exercise choice and control in his or her daily life.			