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:	Sallynoggin D.C.
Name of provider:	St John of God Community Services CLG
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	05 & 06 June 2024
Centre ID:	OSV-0002890
Fieldwork ID:	MON-0035062

About the designated centre

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

Sallynoggin is a designated centre operated by St John of God Community Services Company Limited by Guarantee. This designated centre is comprised of three individual houses located within short walking distance from each other in a suburban South County Dublin area. One house is a detached two storey building that can provide full-time residential services for up to four residents. The remaining two houses are located beside each other with one house able to provide full-time residential services for up to five residents and the other house able to accommodate up to four residents. There is a person in charge appointed to manage the centre. They are also the person in charge of another designated centre located nearby. They are supported in their role by two supervisors and report to a senior manager. The staff team comprises of nurses, and social care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 5 June 2024	09:30hrs to 16:30hrs	Jacqueline Joynt	Lead
Thursday 6 June 2024	09:15hrs to 14:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The inspection was facilitated by the person in charge and two front-line supervisors for the duration of the inspection. The inspector used observations and discussions with residents alongside a review of documentation and conversations with key staff and management, to inform judgments on the residents' quality of life. The inspection was carried out over two days. On the first day of the inspection, the inspector was informed about an ongoing infestation within one of the houses in the designated centre. This is discussed further in the report under infection prevention and control.

Overall, the inspector found that that the person in charge and staff were striving to ensure that, residents living in the designated centre, were provided with a quality and safe service. Residents were supported to engage in their community in a meaningful way and were provided with lots of choice in their home. When speaking with the inspector, residents spoke positively about their lived experience in the centre.

The centre comprises of three separate houses. One house is a detached two storey building that provided full-time residential services for up to four residents. The remaining two houses are located beside each other with one providing full-time residential services for up to five residents and the other house can accommodate up to four residents. In each house, residents are provided with their own private bedroom which was decorated to their individual style and choice.

On walking around each of the houses, for the most part, the inspector observed them to have a homely feel. Sitting rooms were observed to be cosy and welcoming, with some residents having their own preferred chair. In one house, to temporarily support the changing healthcare needs of one resident, the main sitting room had been temporarily converted in to a bedroom. There was another sitting room that residents could spend time in. However, the second sitting room was very small and not sufficiently adequate for the amount of residents living in the house.

The inspector was provided the opportunity to observe most of the residents' bedroom. While some required upkeep and repair, most bedrooms presented cosy and homely in nature. Some of the residents were happy to show the inspector their bedrooms, which were observed to be laid out in style and decoration that was of preference to each resident. Bedrooms included, televisions, pictures, family photographs and memorabilia that was of importance to each resident.

The inspector observed that communal spaces, such as the dining room and hallways included ample information posters and notice boards that were part of residents' everyday life in the house and as such made it more individual to them. For example, easy-to-read menu and activity plans, staff on duty, complaints procedures, notices about the HIQA inspection, but to mention a few.

All houses provided residents with a well proportioned garden. In one house a resident's family and their friends called each week to maintain and upkeep the garden and patio area. There were an array of flowers and a welcoming seating area divided into two levels. The two other gardens were spacious with garden furniture for residents to enjoy meals outside if they so wished. However, the external laundry and storage sheds in these gardens required upkeep so that they could be effectively cleaned, in terms of infection prevention and control.

In advance of the inspection, residents were each provided with a Health Information and Quality Authority (HIQA) survey. Nine out of twelve residents chose to complete the surveys. All nine residents were supported by their staff when completing the surveys. Overall, the surveys relayed positive feedback regarding the quality of care and support provided to residents living in the centre. There was positive feedback regarding living in the centre, for example, residents ticked on the survey that the centre was a nice place to live in and that they liked the food and had their own bedroom. Residents were also positive about their day to day choices and ticked that they felt safe in their home, were provided privacy when making calls, had money to spend and were happy with the people in their home; for example, staff and other residents living there.

The surveys also demonstrated that, residents' felt staff knew what was important to them and were familiar with each of their likes and dislikes. They ticked that staff provided help to them when they needed it. Most residents noted that they felt listened to and were included in decision making in their home and overall, were kept informed about new things happening in the centre and in their life.

Most of the residents in the centre attended a day services and on the day of the inspection, many of the residents were attending the services. Where this was not the case, residents were offered a choice of meaningful activities from their home. Where residents chose to go on an evening or weekend activity, the person in charge, as much as possible, ensured there was addition staff on the roster to accommodate such an activity.

The inspector spoke with a number of residents on the day. One resident who had returned from their day service, and had found it a little busy, was relaxing in the sitting room having some quiet time with staff. The resident informed the inspector that they were happy to use the downstairs toilet and shower facility during the period their fellow house-mate was self-isolating while recovering from an illness and required the upstairs communal toilet facility. The person in charge advised the inspector, that where situations like this happened, residents were informed in advance about the situation. Staff asked the resident their opinion on the matter, whilst also being mindful and respectful of the privacy of residents' self-isolating. One resident told the inspector that they enjoyed who they were living with and were eager to help their peers when they were feeling unwell.

Another resident showed the inspector their bedroom. They talked about their love of animals and their planned holiday away with staff where they would visit a farm where there were plenty of animals. The resident appeared excited when talking to

the inspector about their plans and were looking forward to having a break away.

While residents talked their goals relating to activities and holidays they had enjoyed, as well as some places they would like to visit, the inspector found that the documentation relating to residents' goals, their progress as well as new goals required improvement. There were a number of gaps identified within residents personal plans; This is discussed in the quality and safety section of the report.

The inspector observed respectful and caring engagements between residents and staff and management. During the first day, the inspector observed one resident appear anxious around their busy day and about the inspector visiting their home. It was evident from observing staff engagement with the resident that they were aware of how to support them with this worry and how best to alleviate their anxieties around the matter.

Residents were consulted and involved in the running of their home. Residents were provided with household meetings to discuss topics about their home. On review of a sample of recent resident meeting minutes, the inspector saw that items such as choice of community activities, choice of meals, upcoming elections, new staff, change in local management and the complaints process were discussed and decisions made.

In summary, the inspector found that the person in charge and staff were striving to ensure that residents well-being and welfare was maintained and that a person-centred culture was promoted within the designated centre. However, there were a number of improvements needed to the governance and management systems, infection control and medication management arrangements to ensure the service being delivered to each resident living in the centre was, at all times safe and, met their assessed needs and provided good quality care and support to residents at all times.

Capacity and capability

This was an announced inspection. The purpose of the inspection was to inform a registration renewal recommendation for the designated centre.

The inspector found that, the person in charge and staff were striving to ensure that a good quality service was being provided to residents living in the designated centre. However, a number of improvements were needed to ensure that residents were being provided a service that was safe, adequately resourced, effectively monitored and met the needs of all residents

The provider had a number of monitoring systems in place in the centre; these included provider led audits, quality improvement plans and a local auditing system in place, but to mention a few. However, the inspector found that not all audits had taken place as scheduled or were an effective tool in promoting quality

improvements; A number of the deficits, found on this inspection that related to infection prevention and control, medication management and response to risk, had not been identified or appropriately responded to.

Despite a recurring infection control risk relating to vermin, the provider had not taken responsive or timely action to address the issue when it was observed to be ongoing. In addition, the provider had not addressed required premises works in one of the houses within the timeframe as set out in a previous compliance plan from a previous inspection. Furthermore, despite identifying a high number of medication errors, the provider's response had not been effective in reducing their occurrence.

There were clear lines of accountability at individual, team and organisational level so that, for the most part, staff working in the centre were aware of their responsibilities and who they were accountable to. Provider audits and unannounced visits were also taking place and were endeavouring to ensure that a good quality service was provided to residents.

A new person in charge had commenced in their role in May 2024. The person in charge was familiar to the service as they had previously managed the centre. Local management and staff informed the inspector that they felt supported by the person in charge and that they could approach them at any time in relation to concerns or matters that arose. On commencing their role, the person in charge carried out a baseline audit of all areas of services provided in the centre; This was to evaluate and improve the provision of service and to achieve better outcomes for residents. A number of the deficits, found on this inspection, were identified on the audit however, many of the actions had yet to be implemented.

Improvements were needed to ensure that there were effective information governance arrangements in place to ensure that the designated centre complied with notification submission requirements at all times. The person in charge was endeavouring to ensure that all adverse incidents and accidents in the designated centre, were notified and within the required time-frame. However, not all restrictive practices, that had been in place in the centre, were identified or notified to the Chief Inspector on a quarterly basis.

There was a staff roster in place and overall, it was maintained appropriately. The registered provider was striving to ensure that the number, qualification and skill-mix of staff was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre. However, there were three staff vacancies in the centre. As a result, in one house, there was a high reliance on agency staff which overall, was impacting negatively on continuity of care of residents.

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained. All staff had completed, or were scheduled to complete, mandatory training as set out in the centre's statement of purpose. Supervision records reviewed were in line with the organisation's policy. The inspector found that for the most part staff were receiving regular supervision

as appropriate to their role. However, to better ensure good quality care and support was provided to all residents, supervision arrangements for staff, who were employed on a less than permanent basis, was needed.

The inspector found that for the most part, the provider had ensured that the policies and procedures were consistent with relevant legislation, professional guidance and international best practices. They were written for the service and were clear, transparent and easily accessible. However, improvements were needed to ensure that all policies and procedures were reviewed and updated within the regulatory timeframe.

Regulation 14: Persons in charge

Through a review of documentation submitted to the Health Information and Quality Authority, (HIQA), the inspector found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

On speaking with the person in charge during the inspection, the inspector found that they were familiar with residents' support needs and were endeavouring to ensure that they were met in practice. In addition, the inspector found that the person in charge had a clear understanding and vision of the service to be provided and, supported by the provider, fostered a culture that promoted the individual and collective rights of residents living in this centre.

Staff informed the inspector that they felt supported by the person in charge and that they could approach them at any time in relation to concerns or matters that arose.

Judgment: Compliant

Regulation 15: Staffing

The staff team were managed and supervised by a full-time person in charge who was supported by two frontline supervisors. The person in charge was responsible for one other centre; one supervisor was allocated to two of the houses in the centre and one supervisor was allocated to one house in this centre and a house in another designated centre.

The frontline supervisors supported the person in charge in assisting them with the operational oversight of the centre.

The provider had identified the changing needs of residents in the centre and reviewed staffing arrangements and increased staffing levels in one house. The

provider was endeavouring to recruit the additional staff required however, had not been successful in filling all positions to date.

There were three staff vacancies in the centre; The vacancies included three social care worker roles. While these vacancies were being covered, the overall staffing arrangements were impacting on the provision of continuity of staffing in the centre.

The person in charge was endeavouring to ensure continuity of care. The roster demonstrated that familiar relief staff were employed on a regular basis. In one house where agency staff were employed, the person in charge was endeavouring to use the same agency staff as much as possible however, that this could not always be achieved and overall, was unlikely to remain sustainable. Overall, the roster demonstrated that there was a high usage of agency staff working in one of the houses in the centre.

However, on review of a sample of rosters from March to June 2024 the inspector saw that there had been significant reduction of agency staff working in the house since late April.

For the most part, staff who spoke with the inspector demonstrated good understanding of residents' support needs, and overall, were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre.

Judgment: Not compliant

Regulation 16: Training and staff development

On review of the training schedule, the inspector found that the education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice.

The training needs of staff were regularly monitored and addressed to ensure the delivery of quality, safe and effective services for residents.

On a review of the schedule, the inspector found that, for the most part, staff had been provided with the organisation’s mandatory training and that the majority of this training was up-to-date. For example, staff were provided with training in safe medication practices, infection prevention and control, human rights, manual handling, positive behavioural supports, safeguarding vulnerable adults, fire safety, but to mention a few.

The inspector reviewed the supervision schedule in place and a small sample of staff supervision meeting minutes. The inspector found that supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability.

However, unlike permanent staff members, agency staff were not attending staff meetings and receiving a supervision arrangement and this required improvement to ensure all staff, as much as possible, were fully informed and appropriately supervised to ensure good quality care and support to residents.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents in the designated centre. The directory had elements of the information specified in paragraph three of schedule three of the regulations.

Judgment: Compliant

Regulation 21: Records

On the day of the inspection, records required and requested were made available to the inspector.

On the day of the inspection, the person participating in management organised for staff records to be brought to provider's main office board room for the inspector to review.

A sample of 15 staff files (records), were reviewed and the inspector found that they contained all the required information as per Schedule 2.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had valid insurance cover for the centre, in line with the requirements of the regulation.

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

The inspector reviewed the insurance submitted to HIQA and found that it ensured that the building and all contents, including residents' property, were appropriately insured. In addition, the insurance in place also covered against risks in the centre,

including injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The provider had completed an annual review to assess the quality of care and support provided in the service between March 2023 to March 2024 and a copy had been submitted to HIQA in advance of the inspection. The review demonstrated that residents and where appropriate, family, had been consulted in the process. In addition, the provider had completed, as required, six monthly unannounced reviews of the quality of care and support provided to residents living in the centre during 2023, including action plan and timelines. Furthermore, the person in charge and supervision carried out a schedule of audits to ensure that the service being provided was safe and appropriate to the needs of residents

However, overall, the provider had not ensured, that satisfactory management and oversight arrangements, to ensure a good quality service for residents, were in place at all times. As a result, a number of non-compliances were found on this inspection.

The provider had not adequately addressed an infection prevention control risk relating to an infestation in one of the houses in the centre which had been on-going since early May 2024. Subsequent to the inspection, an urgent action was issued to the provider seeking assurances of how they were going to mitigate the risk posed by the infestation. Overall, the timeliness of the provider in addressing the risk was not adequate in ensure the residents' safety.

The provider had not completed renovation works to one of the centre's premises within the timeframe provided on their last compliance plan. The timeliness of completing the works was impacting negatively on the safety and rights of residents.

The governance and management systems in place to ensure that there was safe medication management systems in place was not effective. For example, the provider's response and follow up to identified medication errors, relating to poor practice in administration of medicines, had not been effective in resolving the issue.

The inspector reviewed the schedule of audits that were in place across all three houses in the centre from May until December 2023 however, there was no documents made available to demonstrate the completion of audits for one of the houses from January to April 2024. This had not been noted on the annual report of the centre or on the unannounced six monthly review. This meant that both these audits had not been fully effective in adequately monitoring the quality of care and support provided to residents.

In addition, on review of the infection prevention control audit that was carried out in May 2024, the inspector found that the audit was not effective in identifying many of the current risks. For example, the audit failed to identify many of the infection

prevention and control issues that were identified on the day and in particular, failed to refer to the infestation in one of the houses.

The inspector reviewed a sample of team meetings that had taken place in 2023 and 2024. Minutes of the meetings demonstrated, that overall, the person in charge and staff were striving for excellence through shared learning and reflective practices to ensure better outcomes for residents. However, the minutes of some meetings required improvement. For example, there was limited details in minutes of meetings from one of the houses. This meant that staff who did not attend the meeting, had limited information on what was discussed, shared and actioned.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which accurately outlined the service provided and met the requirements of the regulations.

The inspector reviewed the statement of purpose and found that it described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre.

In addition, a walk around of the property confirmed that the statement of purpose accurately described the facilities available including room function.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector, had been notified and overall, within the required timeframes.

In relation to deficits regarding notifying restrictive practices, this has been addressed under regulation 7.

Judgment: Compliant

Regulation 34: Complaints procedure

On the day of the inspection, the inspector was advised that there were no open

complaints.

The registered provider had a complaints procedure in place that was easily accessible to residents and their family members.

Residents were supported to understand how to make a complaint. The inspector observed that there was an easy-to-read document on how to make a complaint and a diagram on how they are managed on the centre's notice board. In addition, the complaints process was a regular agenda item on residents' household meetings.

The complaints procedure was monitored for effectiveness, including outcomes for residents and ensured residents received good quality, safe and effective services. The inspector reviewed the complaints log and saw that where complaints had been made, they had been dealt with in an appropriate and timely manner with actions follow up and overall, satisfaction levels noted.

Judgment: Compliant

Regulation 4: Written policies and procedures

There were relevant policies and procedures in place in the centre which were an important part of the governance and management systems to ensure safe and effective care was provided to residents, including guiding staff in delivering safe and appropriate care.

On a review of the centre's Schedule 5 policies, the inspector found that not all policies and procedures had been reviewed in line with the regulatory requirement.

As such, the register provider had not ensured that all policies and procedures were consistent with relevant legislation, professional guidance and international best practice relating to delivering a safe and quality service.

For example, policies and procedure relating to;

· Incidents where a resident goes missing

· The use of restrictive procedure and physical, chemical and environmental restraint

· Recruitment, selection and Garda Vetting of staff

· The creation of, access to, retention of, maintenance of and destruction of records.

Judgment: Substantially compliant

Quality and safety

The inspector found that the person in charge and staff were endeavouring to ensure that each resident's well-being and welfare was maintained by a good standard of evidence-based care and support; They were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs.

However, the inspection found that improvements were needed to ensure that a quality and safe service was provided to all residents, at all times. In particular, improvements were needed to the area of infection prevention and control, premises and medication management practices.

On the day of the inspection, there was an infectious outbreak in two of the houses. On visiting the houses, the inspector observed robust infection prevention and control measures in place to mitigate the spread of the infection to other residents and staff. Practices were in place to ensure that care and support provided to residents during this time promoted their safety, wellbeing and rights. This demonstrated good practice in relation to standard precaution management for infectious outbreaks.

However, on review of the centre's overall infection prevention and control systems in place, the inspector found that improvements were needed.

The poor upkeep and repair of areas of the centre's premises were impacting negatively of the effectiveness of the cleaning of the centre. In addition, the un-timely follow up of an infestation in one house within the centre, was not satisfactory and, on the first day of the inspection, required urgent action.

The premises comprised of three houses that were centrally located in a community with access to local amenities, services and public transport which supported residents' autonomy to engage and connect with their local community. The internal layout of the premises encouraged a homely and relaxing environment for residents to enjoy.

A renovation of one of the houses, so that it better met the changing needs of the residents living in it, had been identified since the last inspection in May 2021. There had been a delay in completing the works, as alternative locations for residents to move to, was not available at the time. This meant that, while on the day of the inspection, suitable alternative accommodation had been sourced and renovation works were due to start in July 2024, the currently layout of the designated centre was not meeting the needs of all residents.

Individual and location risk assessments were in place to ensure that safe care and support was provided to residents. Residents were supported to partake in activities they liked in an enjoyable but safe way through innovative and creative considerations in place. The risk register had been recently reviewed and updated.

However, improvements were required to the register to ensure that all presenting risks identified on the day of the inspection, in particular, poor medication management practices and ongoing infection prevention and control issues, were better reflected in the register.

Staff were provided appropriate training in the safe administration of medicine, including regular refresher training. A staff member showed the inspector the layout of the medication room as well as the medication cabinets and systems in place. Overall, the staff member was knowledgeable of safe medicine management practices. However, a significant improvement was required to practices in place that related to the administration, storing and recording of residents' medication.

While there were written policies and procedures for the management of medicines in the centre, including for the prescribing, storage, disposal and administration of medicines the inspector found that the medicine arrangements and practices were not always in accordance with the provider's associated policy.

Each resident was provided with a personal plan that included an assessment of their health, personal and social care needs. There were care plans in place that included information on how to support the resident’s needs. However, on review of a sample of plans the inspector found that not all residents had been provided with an annual review of their plan, in addition there were a number of gaps within the plans.

Overall, the provider and person in charge promoted a positive approach in responding to behaviours that challenge. There were systems in place to ensure that where behavioural support practices were being used, they were clearly documented and reviewed by the appropriate professionals on a regular basis. However, some improvements were needed to ensure that all plans were updated on an annual basis.

There were restrictive practices in place in the centre. The person in charge had recently reviewed all restrictive practices in place. The review found that a number of restrictive practices had not been identified and as such had not been in line with best practice or the provider’s policy.

The person in charge and staff facilitated a supportive environment which enabled the residents to feel safe and protected from all forms of abuse. There was an atmosphere of friendliness, and the residents' modesty and privacy was observed to be respected. Safeguarding was included on the agenda of staff meetings. Where incidents had occurred, the inspector found that, they have been followed up appropriately and in line with best practice.

Systems in place for the prevention and detection of fire were observed to be satisfactory. There was suitable fire safety equipment in place as well as appropriate systems to ensure it was regularly serviced and maintained. There was emergency lighting and illuminated signage at fire exit doors. Fire drills were taking place at suitable intervals and where issues were identified, for the most part, they were followed up in a timely manner. Local fire safety checks took place regularly and

were recorded however, a review of the effectiveness in one house, was required.

Regulation 17: Premises

On a walk around of all three houses the inspector observed them to appear tidy, and for many of the areas, clean. However, there were a lot of improvements needed to the upkeep, repair and cleanliness of a number of facilities, fixtures and fittings and areas inside and outside both houses. These, these have been addressed under regulation 27.

The provider had failed to bring regulation 17, premises back into compliance within the previous compliance plan timeframe. This was to so ensure that the premises provided better accessibility and that it met with infection, prevention and control standards. At the time of the last inspection, while funding had been secured to carry out major renovations on one of the houses, the provider was finding it difficult to source alternative accommodation for residents to temporarily stay in.

While the provider had made some interim adjustments to the layout of one of the houses, this had been an interim measure until the renovation works had been completed but overall, was not a suitable long term measure. The timeliness of the provider to complete the works was not satisfactory and was negatively impacting on residents living in the house and in particular, in relation to ensuring their safety and promoting their rights.

However, on the day of the inspection, the inspector was informed that alternative accommodation had been sourced and that the premises work was due to commence in six weeks' time, with an estimated completion date in December 2024.

A comprehensive action plan, which included person centred transition plans for each resident, information on funding, timelines and floor plans was provided to the inspector at the end of the inspection.

Overall, the inspector found that until the renovations works were completed, the designated centre was not adequately meeting the current assessed needs of all residents. The situation was impacting on residents' safety in terms of in infection prevention and control, and on their rights, in terms of privacy, dignity and independence.

Judgment: Not compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of regulation 20. For example, on review of the guide, the inspector

saw that information in the residents' guide aligned with the requirements of associated regulations, specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services, and the complaints procedure.

The guide was written in easy to read language and was located in an accessible place in the designated centre; There was a copy of the residents' guide available to everyone in the house.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had ensured that the risk management policy met the requirements as set out in the regulations.

There was a risk register specific to the centre, and for the most part, it addressed individual and centre risks. The risk register had recently been reviewed and updated in May 2024.

The person in charge had completed a range of risk assessments, which for the most part, included appropriate control measures to mitigate or reduce the potential risks.

However, a review of the control measures included on the safe medication risk assessment, improvements were needed to ensure that they were effective in mitigating the risk of further medical errors and in particular, relating to risks association with administering medication as prescribed.

In addition, on review the risk assessment in place for the rodent and insect infestation in one of the houses, the inspector found that a review and update was need to ensure the assessment clearly included the potential risk and likely harm the infestation could cause.

Furthermore, a review of the control measures was needed so that they included the additional measures due to be implemented.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While this inspection demonstrated the provider and person in charge had good arrangements for the implementation of standard precautions for instances where there were infectious outbreaks, further improvements were required to ensure all

areas of infection prevention and control were suitably managed and controlled for.

On review of a pest control report, the inspector saw that the infestation of vermin had been identified on 9th of May 2024. The pest control company returned on the 10th of May where vermin activity remained. On the day of the inspection, it was unclear as to the status of the infestation. On speaking with staff, the inspector was informed about current sightings of specific type of vermin in the sitting room/staff sleepover room, the office and a bathroom.

While the organisation's health and safety officer was contacted for advise, and a risk assessment regarding the infestation was carried out, overall, the inspector found that the response by the provider was not timely or effective in dealing with the infestation or reducing the risks it posed.

In addition, assurances were not in place to demonstrate that the provider was fully aware of the potential risks and harm the infestation might result in. This meant that there was insufficient information regarding the potential harm and health risks caused by the infestation to allow effective control measures to be put in place.

On the day of the inspection, the person in charge arranged for the pest control company to pay an urgent visit. The company arrived at the house in the afternoon and vermin were found. A recommendation to spray the house to mitigate the infestation was made. It was also noted that until the house was appropriately sealed, that there was a potential on-going risk of further infestations.

An urgent action was issued to the provider regarding this issue. Overall, the provider submitted appropriate assurances that reduced the risk.

In addition to the above, the inspector observed areas within the three houses in the designated centre that required upkeep and repair and in some places, a deep clean. Poor upkeep and repair meant that these areas could not be cleaned effectively and in turn posed a potential risk to residents' health and safety in terms of infection, prevention and control.

For example, below are a sample of observations during a walk around of the centre:

A shower chair was observed to have rust and ingrained dirt, in addition, the shower chair was not being cleaned in line with the manufacturer’s instructions.

A cooker hood and surrounding areas of the cooker was observed as unclean and required a deep clean.

Not all food in fridges were observed to have a 'date of open' label on it. Two sets of dustpans and brushes were observed to be worn, dirty and not fit for purpose.

The cement type of flooring on the external laundry room and storage room (that contained personal care items and personal protective equipment) could not be effectively cleaned, in infection prevention and control terms.

A small downstairs internal storage room, where the house's hoover was stored as well as PPE, was observed to have a smell of damp. mould was visible on the wall in one area of the room.

Two fire extinguishers in a hallway were observed to have a layer of heavy dust on them.

Cracks were observed on kitchen door frames.

The floor was badly scuffed in one of the staff offices.

A downstairs bathroom door was observed to be badly scuffed. Two bathroom floor tiles had been replaced by wood, which could not be effectively cleaned. A toilet hand rail was observed to be rusty

An upstairs shower facility was observed to have a lot of mould on the ceiling area just above the showered. The Velux window in same room was observed to have mould and there was no toilet roll holder in place.

In another shower facility, the shower pole was observed to have a lot of rust.

There were holes left in timber where double doors had been removed from as dining/sitting room area. In the same room, Where a door closing devise had been replaced, holes in the timber had not been filled in.

A leather couch was observed to have a lot of cracks which made it difficult to be effectively cleaned.

A freezer in an external shed containing food was observed to have a build-up of frost and there were no temperate check system in place for same.

The kitchen window in one house was observed to have a build-up of mould and the paint on the window sill was chipped .

Some of the above deficits had been identified in a recent audit completed in May 2024 however, some had been identified on the last HIQA infection prevention and control inspection in February 2023.

Judgment: Not compliant

Regulation 28: Fire precautions

For the most part the provider was endeavouring to ensure that appropriate fire safety management systems were in place and were effective. However, some improvements were needed to ensure the safety of residents at all times.

A fire drill carried out in August 2023 identified an issue that impacted on the

swiftness of residents leaving their home, in the case of fire. The inspector found no documentation in place to demonstrate appropriate follow-up subsequent for the identified risk.

Another fire drill in May 2023 identified the same issue again however, on this occasion, there had been comprehensive follow-up; for example, a risk assessment with appropriate control measures was put in place, the personal evacuation plan was updated, a psychology referral was made (to support resident with their evacuate plan). In addition, social stories were completed and a skills teaching programme put in place.

Overall, while this was a significant improvement, the overall the timeliness in following up from the first issues was not satisfactory and place an potential risk on residents and staff during evacuation procedure.

There centre had put in place fire management systems which endeavoured to ensure residents' safety at all times. These included containment systems, fire detection systems, emergency lighting, and fire fighting equipment. They were all subject to regular checks and servicing by an external company. In addition, local fire safety checks were carried out. However, not all checks were found to be effective. For example, a fire escape door at the back of one house was found to have a broken curtain blind pulled down over the door. This posed a potential risk of residents not been able to escape from that door as swiftly as required.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

In one of the houses in the centre, the inspector observed that the medication cupboard was not tidy, well organised or in good state of repair. The inspector observed chipped timber on the cupboard door and old grubby blue tack stuck to the inside of the lower door. This meant that the facilities for the secure and safe storage of medications was not suitable and required improvements.

On review of medications in the same house, the inspector observed that not all opened medications had been appropriately labelled with an opening date. This meant that there was a risk of residents being administered medications that were out-of-date or no longer effective.

Improvements were needed to ensure that, at all times, residents' medicines were administered and monitored in line with best practice as individually and clinically indicated. The designated centre's incident log had recorded six medication errors between March 2024 and May 2024. The majority of the errors related to administration of medication errors. For example, on a number of occasions, it was unclear if a resident was administered their medication as prescribed. These deficits had been included in the centres medication risk assessment however, the control

measures in place were not effective.

In addition, on the day of the inspection, the inspector found that not all medications had been administered as prescribed. Furthermore, where a resident had been administered their medication it had not been documented in their medical administration report sheet. Where a resident was prescribed a medication cream twice in one day, it had only been recorded as administered once a day.

The person in charge completed a baseline audit of the centre in May 2024 and included a medication audit. The audit included a number of actions to rectify the deficits however, further improvements were needed considering the deficits found on the inspection day.

Overall, this meant that the provider could not be assured that system in place for medication management were effective and safe at all times. This also meant that there was a risk to residents health and wellbeing as they were not always provided medication that was prescribed to them.

Where residents were prescribed PRN, (taken as needed), medication there were PRN protocols in place. However, on review of a sample of PRN protocols for two residents, the inspector found that they were out of date since 2021. While one resident's care plan included PRN information (similar to that found on a protocol), this was not the same for all residents' care plans. This posed a risk to residents' safety as the information to support staff safely and correctly administer PRN medication, was potentially no longer appropriate.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Not all residents were supported to review their goals on an annual basis, and where goals were in place, the progress or update on the goals was not always appropriately recorded. Overall, this meant that the reviews of residents plans were not effective and were not representative of what was current in their lives.

On speaking with staff, the inspector found that not all staff were familiar with residents current goals and seemed unclear why residents' personal plan meetings had not taken place, or when they were due to take place. For example, on the day of the inspection, on requesting a copy of a resident's personal plan meeting, the inspector was provided with the most up-to-date version, which was in 2022.

Many of the deficits above had been identified by the person in charge in a recent audit (May 2024) of residents' personal plans. The audit identified a number of gaps and improvements required. For example, a number of support plans had not been reviewed in a timely manner, there were gaps in keyworker signatures, contract of care plans required updating, information related to 2022 or further back, there

were inaccuracies noted, and in some plans, no evident of goal review.

Subsequent to the audit, the person in charge drew up an action plan, that included all improvements and updates required for each resident's personal plan. However, as this had just been completed, many of the actions had yet to be implemented. This meant that information that was personal to residents and about them remained out of date and in some cases, inaccurate.

However, the inspector was shown a new template (May 2024) for an improved personal plan process that would better support the effectiveness of the process and in particular, the reviews of residents' plans. For example, the new process included a residents' easy read evaluation of the personal plan process, keyworker meeting template, SMART goal plan and goal template, but to mention a few. There was also new guidance included for keyworkers on how to develop plan and implement a review of a person centred plan. The inspector was informed that the new process had already been piloted and had resulted in positive outcomes for residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider and person in charge promoted a positive approach in responding to behaviours that challenge.

Where appropriate residents were provided with positive support plans, however, not all plans had been reviewed on an annual basis. For example, on review of one resident's positive behavioural support plan, dated February 2023, the inspector found that a review of the plan was outstanding by three months.

Restrictive practices were logged and regularly reviewed and it was evident for a number of restrictive practices that efforts were being made to find alternatives to reduce or cease some restrictions. However, some further action was needed to ensure that all restrictions included a clear reduction plan.

In addition, a recent audit completed by the new person in charge identified a number of restrictive practices that had not been submitted to the organisation's rights committed or notified to HIQA as required. This meant that the provider was not ensuring that all restrictive practices in place in the centre were the least restrictive, for the shortest duration.

Judgment: Substantially compliant

Regulation 8: Protection

Overall, the inspector found that in terms of safeguarding, residents were protected by practices that promoted their safety.

The organisation's safeguarding policies and procedures had been reviewed and updated in April 2024.

All staff had been provided with training in safeguarding and protection of vulnerable adults. Staff who spoke with the inspector were aware of the safeguarding policies and procedures in place to protect residents.

Where safeguarding incidents had occurred in the centre, the person in charge had followed up appropriately and ensured that they were reviewed, screened, and reported in accordance with national policy and regulatory requirements.

Residents' surveys demonstrated that they knew who they could talk to if they were feeling unhappy or worried about anything.

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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sallynoggin D.C. OSV-0002890

Inspection ID: MON-0035062

Date of inspection: 05/06/2024 & 06/06/2024

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 provider has an ongoing recruitment drive underway, which includes open days, public advertising and social media advertising. The location is highlighted as a high priority for staffing upon successful recruitment. 1 staff who is on extended leave is due back in August 2024. 1 new staff commenced on 08-07-2024. A second staff is due to commence on the 20th July 2024.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Daily duties have been amended to include that agency staff will read minutes of team meetings if not in attendance and sign when read. Team meeting minutes have been amended to include a section to review whether previous minutes have been read and signed by all staff, including agency staff. Agency staff will attend team meetings going forward when on duty for the scheduled meeting (as of 14th July 2024) The governance logs for all three houses will be combined into one DC by log by 26-07-2024. Shared regular agency staff between the houses have been divided between the two supervisors who will complete supervisions with these staff. A schedule is now in place for a first supervision.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
On receipt of the report from ecolab in relation to the silverfish infestation it was recommended that the house was to be sprayed to mitigate the infestation. The company advised that the residents would need to vacate the house for a minimum of six hours and a maximum of eight hours after the spray has taken place. Since the inspection the following actions have been completed

- The risk assessment in relation to the infestation has been updated and all controls will remain in place until the building works have been completed.
- The company returned to the house on the 10th of June as planned.
- The company returned to the house and completed the spray.
- Ecolab attend the house weekly and will continue to do so until the building works have taken place to monitor the activity and mitigate the risk.
- The building works will commence on 30-09-2024. Once the building works have been completed the house will be sealed which eliminate the risk of mice entering the premises.

The renovation works remain in the planning phase. There has been a slight delay since the inspection date as a change of architect was required. A new architect is in place now and has been onsite to review the plans. Contractors are scheduled to commence the works on the 30-09-2024, with an estimate completion date of 30-01-2025.

The medication Risk assessment has been reviewed to include additional contextual information in the risk descriptor and additional mitigating controls.
An SCL monthly checklist has been developed to provide ongoing local oversight of day-to-day medication practices. The PIC is scheduled to complete quarterly medication audits. Medication has been added to the team meeting minutes template as a standing agenda. Staff are now assigned on the roster for medication duties. The handover document has been amended to include a medication specific section.
A mandatory team meeting was held with all staff to discuss medication incidents and challenges in relation to medication ordering, supply, administration, recording and disposal. A local medication procedure has been developed on foot of this meeting to guide practice.

The PIC has shared the identified learning from the inspection with the Quality team who undertake the provider audits.

SCLs and PICs have discussed the detail required in team meeting minutes and improvements are expected in this regard. The PIC has included a review of team meeting minutes on the quarterly human resources audit to enhance governance in this

regard.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The following policies and procedure have been reviewed and circulated since the inspection date;
· Missing persons procedure
· Enabling restriciton free environments
· Garda Vetting
The data retention policy in the schedule 5 on the day of inspection was not the most up to date version. The most up to date version (July 2023) has been circulated to the houses since the inspection date.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The renovation works remain in the planning phase. There has been a slight delay since the inspection date as a change of architect was required. A new architect is in place now and has been onsite to review the plans. Contractors are scheduled to commence the works on the 30-09-2024, with an estimate completion date of 30-01-2025.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk assessment for the infestation has been reviewed to include the additional measures implemented post inspection in relation to weekly reviews by the pest control company, the house spray to reduce the risk, and additional contextual information in relation to allergies.

The risk assessment for medication has been reviewed to include additional contextual information in the descriptor and additional controls implemented post inspection, such a assigned staff to medication, monthly SCL medication checklist, quarterly medication audits, development of a local medication procedure, quarterly NIMS review including analysis of trends and control effectiveness.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
On receipt of the report from ecolab in relation to the silverfish infestation it was recommended that the house was to be sprayed to mitigate the infestation. The company advised that the residents would need to vacate the house for a minimum of six hours and a maximum of eight hours after the spray has taken place. Since the inspection the following actions have been completed
• The risk assessment in relation to the infestation has been updated and all controls will remain in place until the building works have been completed.
• The company returned to the house on the 10th of June as planned.
• The company returned to the house and completed the spray.
• Ecolab attend the house weekly and will continue to do so until the building works have taken place to monitor the activity and mitigate the risk.
• The building works will commence on 30-09-2024. Once the building works have been completed the house will be sealed which eliminate the risk of mice entering the premises.

• A referral has been submitted to OT to replace the shower chair in one location.
• The cooker hoods in all locations have been cleaned and a monthly clean has been added to the cleaning checklist.
• Food labelling has been discussed at team meetings with all staff.
• The cement flooring in the outdoor sheds has been scheduled for painting in one location on 26-07-2024 and in the second location by 02-08-2024.
• The downstairs storage room in one location has been cleared out. Domestic staff have cleaned the mould that was building and this has been added to the domestic staffs monthly tasks.
• The freezer in one location has been defrosted.
• Thermometers have been ordered for the freezers in all three locations, and temperature checks have been devised. These will be implemented on receipt of the thermometers (estimated delivery of 02-08-2024)
• Dusting of fire extinguishers has been added to the cleaning checklists on a monthly basis.
• The cracks in the kitchen doors, holes in timber doors, and scuffed bathroom doors, have been reported to maintenance for resolution. These will be completed by 30-08-2024.

• The wooden replacement tile hass been reported to maintenance for a resolution in terms of providing a washable surface. Timeframe for completion 30-08-2024.
• Mould on the velux window has been cleaned by domestic staff. This has been added to the domestic tasks list on a quarterly basis.
• Rust on shower poles has been reported to maintenance and a completion date of 30-08-2024 has been given.
• The toilet roll holder in the upstairs bathroom is on a schedule for repair by 09-08-2024.
• The mould on the kitchen window has been cleaned and has been added to the cleaning checklist on a monthly basis.
• The damaged leather sofa surface; the residents are researching their preferences for a new sofa. As an interim measure a sofa cover has been ordered to ensure a washable surface. Timeframe for a new sofa, given delivery lead in times, of 30-10-2024

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The blind has been removed from the rear exit door.
Staff fire safety checklists have been discussed at the recent team meeting. SCLS now complete forthnightly checks of staff fire safety checks and sign off on same.
Staff now send all fire drill observer reports to the PIC and SCL following each fire drill to ensure any issues identified are responded to in a timely manner.
PIC now completes quarterly fire safety audits.
The skills teaching program has commenced for one individual in line with her PEEPS.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All PRN protocols are now in date.
A revised MARS chart was developed for the individual in relation to double sign off by staff.
The medication Risk assessment has been reviewed to include additional contextual information in the risk descriptor and additional mitigating controls.
An SCL monthly checklist has been developed to provide ongoing local oversight of day-to-day medication practices. The PIC is scheduled to complete quarterly medication audits.
Medication has been added to the team meeting minutes template as a standing agenda.

The blue tac has been cleaned off the medication press.
A maintenance request has been submitted for the chipped timber on the medication cabinet and is due for completion by 30-08-2024.
Staff are now assigned on the roster for medication duties.
Recruitment of staffing in one location plays an integral role in reduction of medication errors and consistency of approach. 1 staff has been recruited post inspection and one staff who is on extended leave is due to return in August 2024. A third staff is due to commence on 20th July 2024.
The handover document has been amended to include a medication specific section.
A mandatory team meeting was held with all staff to discuss medication incidents and challenges in relation to medication ordering, supply, administration, recording and disposal. A local medication procedure has been developed on foot of this meeting to guide practice.

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:
The new documentation has now been launched. Roll out of its use has commenced and team meetings are scheduled to provide support and guidance in relation to its initial launch. (timeframe 30-07-2024)

Scheduling of circle of support meetings with residents and their families is in progress. Three have been completed post inspection and one is scheduled for August. (timeframe 30-09-2024)

A follow up check on actions from baseline audit is scheduled to be completed by SCLs in August 2024.

The PIC is scheduled to complete another thorough personal plan audit in October 2024 to ensure roll out of the new documentation is effective.

Recruitment of staff plays an integral role in the standard of record keeping in personal plans. One staff member has been recruited since the inspection and one staff member who is on extended leave is due to return in August 2024. A third staff member is due to commence on 20th July 2024.

Regulation 7: Positive behavioural	Substantially Compliant

support	

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Referral submitted to psychology for review of one individual's BSP.

One restrictive practice in relation to night checks has been removed since the inspection.
All identified restrictive practices now have local protocols in place and have been referred to the EHRC. All identified restrictive practices will be notified to the chief inspector on the quarter two notifications.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/01/2025
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.	Substantially Compliant	Yellow	30/01/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/10/2024

Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/01/2025
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.	Not Compliant	Orange	30/01/2025
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	30/01/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for	Substantially Compliant	Yellow	17/07/2024

	responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/01/2025
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/09/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that	Not Compliant	Orange	30/09/2024

	medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	30/07/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review	Substantially Compliant	Yellow	17/07/2024

	and update them in accordance with best practice.			
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
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/09/2024
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/07/2024