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

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| Name of designated centre: | DC7 |
| Name of provider: | St John of God Community Services CLG |
| Address of centre: | Kildare |
| Type of inspection: | Unannounced |
| Date of inspection: | 12 August 2024 |
| Centre ID: | OSV-0002944 |
| Fieldwork ID: | MON-0044273 |

## About the designated centre

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

DC 7, operated by St. John of God Community Services, is registered for 25 residents. The twenty five residents, both male and female, live across six terraced homes and one apartment backing onto a campus setting located in a large town in Co. Kildare. Within the main buildings, each resident has their own bedroom and share common areas with other residents. Residents with an intellectual disability and mental health issues are supported by social care workers, nursing staff and a healthcare assistant. Some residents attend various day programmes provided by St. John of God Kildare services, and some residents are supported to participate in activities in their local community or stay at home on days that they choose. Residents have access through a referral system to the following multi-disciplinary supports psychology, psychiatry and social work. All other clinical support is accessed through community-based primary care with a referral from the individuals GP as the need arises.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 19 |

## 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 |
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| Monday 12 August 2024 | 10:55hrs to 18:10hrs | Karen Leen | Lead |
| Monday 12 August 2024 | 10:55hrs to 18:10hrs | Erin Clarke | Support |

## What residents told us and what inspectors observed

From what residents told the inspectors and based on what they observed, residents were supported to enjoy a good quality of care in this centre. This report outlines the findings of an unannounced risk inspection of this designated centre. The inspection was conducted to assess compliance with the regulation following receipt of solicited information to the Office of the Chief Inspector. Overall, the inspectors of social services found that the provider had taken a number of responsive steps to meet the identified changing needs of residents and to bring about compliance with the regulations. However, further improvements were required in relation to a number of regulations, such as Regulation 17: Premises and Regulation 23: Governance and Management. The inspectors noted that there was continued non-compliance with Regulation 17 regarding the premises at the designated centre. This non-compliance had been previously identified during inspections and provider-led audits, but there was no specific time frame or action plan in place for addressing it. The inspectors found that non-compliance with Regulation 17: Premises had a negative impact on Regulation 23: Governance and Management due to the lack of assurances regarding ongoing funding and maintenance of the centre. Further improvements were also required in relation to Regulation 15: Staffing and Regulation 34: Complaints Procedure.

The designated centre is divided into six adjoining houses and one apartment that backs onto the provider's campus setting. The designated centre has a capacity of 25 residents; at the time of the inspection, there were five vacancies. The centre is divided into three sections, two sections making up four houses and the final section making up two houses plus the apartment. There was a person in charge of the designated centre and three social care leaders, one assigned to each section of the centre. The centre's rosters were completed, and staff were assigned to each individual house. Staff discussed with the inspectors that, at times, staff may offer support to other houses within the designated centre if required. However, the majority of their time is spent in the house the roster system has assigned them to. The inspectors visited all seven houses during the course of the inspection and met with 17 residents; one resident was away with family and not due to return until the following day, and another resident was participating in a day trip. On the day of the inspection, the person in charge was on planned leave; the inspection was supported by a social care leader assigned to the designated centre and a member of management appointed by the provider to support the inspection process. The inspectors used interactions with residents, observations of care and support provided by staff, conversations with staff and a review of the documentation to form judgments on the quality of care being provided in the designated centre.

Inspectors saw that six of the seven houses were in need of refurbishment. On arrival at one of the houses in the designated centre, inspectors observed a black stain on the flooring of the kitchen area, which took up the majority of the kitchen space. Residents discussed with inspectors that the stain had been in the kitchen for a long time and that they had complained to the provider about the required

refurbishment. One resident told the inspector that they had informed the staff team at residents' meetings and expressed their ongoing wish to have the kitchen works carried out. The inspectors observed that the interior of six of the seven houses required paintwork. Due to the changing needs of residents in one house in the designated centre, inspectors observed a high volume of assistive equipment was required in order to ensure accessibility for residents. During the walk through of this house inspectors observed three walking frames and three wheelchairs being stored in the kitchen area, leading to poor space for residents to manoeuvre their equipment when in use within the home.

In addition to the needed premises upgrade works, the provider identified that the centre was not suitable for one resident due to its location and had referred the case to the funder following several adverse events noted to the Chief Inspector. However, at the time of the inspection, there was no update or plan of alternative accommodation for this resident.

One resident told the inspectors that their day service was closed for two weeks and that they were spending time at home. The residents told the inspectors that they had plans for later in the day, but as they were off for the week, they were taking some time to relax in their homes. One resident told the inspector that they were expecting family to visit them later in the day and that they were looking forward to seeing them. Inspectors had the opportunity to speak to this resident's family about the service provided. The family told the inspector that they could not fault the care that was provided to their loved one by the staff in the centre. The family told the inspector that the staff team are extremely dedicated and that staff are supportive of their loved one at all times. The family discussed that their loved one had gone through a period of poor health and that staff had communicated throughout with a range of supports available to help their loved one return to a good level of health. The family told the inspector that the premises were in need of updating and general repair. They also noted that the changing needs of their loved ones and their peers within the designated centre were causing space issues. Several residents were using mobility aids, and the communal area was becoming crowded. The family noted that the house in the designated centre where their loved one lived had a vacant room for one resident, this vacancy had led to more space in the communal areas of the house and more space for the assistive equipment. However, the family noted that outside of repairs being required to the premises, they were happy that their loved one was receiving the highest quality of care and that they supported in a manner that focused on the individual.

Inspectors observed that residents were freely accessing all areas of their homes. Residents were seen relaxing in the garden, chatting to staff and peers while enjoying lunch outside. One resident told the inspectors that they have lived in DC 7 for many years and that the staff are very kind to them. The resident told the inspector that they like to go to their day service every day, and they are not always happy when the day service closes for the summer break of two weeks. The resident told the inspectors that staff keep them busy with different activities such as walks in the park, cinema, shopping trips and meals out, but they really look forward to the end of the two weeks when they can go back to day service. The resident told the inspector they love their home but like to visit their friends in the

day service, too.

There was a high level of compliance with mandatory and refresher training. All staff were up-to-date in training in required areas such as safeguarding vulnerable adults, infection prevention and control, manual handling, and fire safety. Staff spoken with were knowledgeable regarding their roles and responsibilities in ensuring the safety of care. Staff could discuss the changing needs of residents to the inspectors and the supports available in the centre.

There was evidence of residents making complaints that had not been recorded and progressed through the formal complaint process, including a 30-day formal response sent to the complainant in line with the provider's policy. Residents attended 'Speak up' meetings in the centre that aimed to update residents on various aspects of the service and seek residents' input into the centre's operation. The meetings of these minutes indicated that residents were happy living together but were frustrated at some premises issues in the centre. For example, residents said that a floor in one kitchen needed to be repaired, and pest control had become an issue. Another resident was unhappy with the transport available in their home, and they missed going out for dinner with the other residents due to assessable vehicle constraints.

In summary, inspectors found that residents were in receipt of a person centered service and led active, busy and supported lives. Residents enjoyed access to both community and home-based activities, and those spoken to were aware of who to go to if they had any concerns or complaints. However, as discussed, the significant refurbishments required to the designated centre were impacting the comfort and accessibility for residents in their homes, leading to a number of complaints and dissatisfaction by residents. Complaint resolution for residents was further impacted as the provider could not set dates for the commencement of the required refurbishment.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service provided.

## Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service and how effective it was in ensuring that a good quality and safe service was being provided. Overall, there was a clearly defined management structure that identified the lines of authority and accountability, and staff had specific roles and responsibilities in relation to the day-to-day running of the centre. However, due to a number of resource issues in the centre pertaining to the maintenance and upkeep of the houses and vehicles in line with residents' ageing needs and the centre, the provider could not demonstrate

they had sufficient resources available to ensure effective delivery of care and support.

There was a clearly defined management structure in place, and staff members were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was lead by a person in charge was present in the centre regularly and they were supported by three social care leaders. Each of the social care leaders had responsibility for a number of identified houses that made up the designated centre. While the person in charge had responsibility for additional services, the inspectors found that governance arrangements facilitated the person in charge to have adequate time and resources in order to fulfill their professional responsibilities.

The inspectors could not access all documentation requested on the day of the unannounced inspection due to the absence of key management stakeholders. The inspectors found that management structures had been put in place due to the size of the designated centre to support residents and staff teams; however, this made it difficult for staff to retrieve all pertinent information for inspectors. The inspectors acknowledge that information requested that could not be accessed on the day of the inspection was provided the following day.

The inspectors reviewed the provider's last two six-monthly provider-led audits and the latest annual review. They found that although the audits focused on the quality and safety of care and support provided for residents, they failed to identify clear actions and timelines for outstanding work required for the centre, with particular reference to the outstanding premises refurbishment.

The provider ensured that suitably qualified, competent, and experienced staff were on duty to meet residents' current assessed needs. However, on the day of the inspection, the centre had three full-time equivalent staff vacancies, which impacted the continuity of care and support provided to residents in the designated centre.

Inspectors reviewed the staff training matrix, which indicated that staff had completed training in mandatory areas and specific training to meet the identified health needs of residents where required. The person in charge also maintained the training records for relief staff working in the designated centre. The education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice. A supervision schedule and supervision records for all staff were maintained in the designated centre.

The provider had developed a complaints policy, which was available and reviewed in the centre. The complaints procedures were also outlined in the statement of purpose and an easy-to-read document on managing complaints.

## Regulation 15: Staffing

The inspectors reviewed the centres actual and planned rosters from May, June and

July and saw that, for the most part, there was sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents on a daily basis. The staff roster was maintained appropriately, and the times worked by each person, including the person in charge and deputy managers, were clearly identified. However, there were three staff vacancies in the centre on the day of the inspection. The inspectors noted that while the person in charge had endeavoured to provide continuity of care as much as possible by employing the same relief staff, this could not always be guaranteed resulting in a number of different staff providing support in the centre. For example, on the week commencing the 10th of June 2024 the inspectors noted six relief and three agency staff being utilised in the centre, covering a total 25 shifts in the designated centre in a seven day period. The inspectors acknowledge that the provider had implemented an unfunded business case increasing the centres whole time equivalent staffing in order to meet the change in residents' assessed needs.

The inspectors observed staff engaging with residents in a respectful manner and it was clear that staff had knowledge of each residents assessed needs. Staff spoken to during the course of the inspection were aware of residents changing needs and the supports that had been put in place in order to meet the needs of each resident in the centre. The inspectors found that staff had the necessary competencies and training to support residents living in the centre.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained. The inspectors reviewed the staff training matrix in the centre for 21 staff and eight relief staff. Each staff member had completed training listed as mandatory in the provider's policy, including fire safety, safeguarding, manual handling, infection prevention, and control. A small number of staff were due refresher training in areas such as manual handling and CPR; the inspectors found that the person in charge had identified this, and staff had been booked into upcoming training courses. Staff had also completed additional training in line with residents' assessed needs, such as dementia, dysphagia and diabetes training.

Staff meetings were occurring in the centre; the inspectors reviewed staff meetings held in each house that make up the designated centre in April, May, June and July and found the content to be resident-focused. As the designated centre consisted of six houses and one apartment, the inspectors observed regular meetings between the person in charge and the three social care leaders involved in the governance and management of the centre.

Judgment: Compliant

## Regulation 21: Records

The inspectors found that not all records requested during the course of the inspection could be provided to the inspectors. The designated centre consists of seven houses, with the management structure consisting of a person in charge and three social care leaders. Each social care leader was responsible for identified houses within the centre in line with the statement of purpose. The person in charge and two of the social care leaders were on leave on the day of the inspection, which led to several requested documents not being available for review. For example, when requested, staff could not provide the inspectors with documentation concerning incident management reviews for June and July, rosters for all of the houses that made up the centre and the complaints log held by the person in charge. The inspectors acknowledged that the barrier to reviewing this information was due to the size of the centre and the absence of relevant stakeholders on the day of the inspection. The provider supplied all requested records to the inspectors within 24 hours of the inspection.

Judgment: Substantially compliant

## Regulation 23: Governance and management

While provider audits were effective at identifying risks, the inspectors noted that time frames had not been implemented in relation to a number of outstanding works in the designated centre in relation to the upkeep and repair of the premises across six of the seven houses. For example, the six-monthly provider-led audits completed in May of 2024 identified that flooring in one of the houses had significant damage following a leak and required replacement. This had been identified within the designated centre two years prior, and no action plan or time frame had been put in place for the completion of this work. Additional outstanding refurbishment work, such as new kitchens, was required in six of the houses, and there was no time frame or action plan for how residents would be supported during this period of refurbishment.

Furthermore, the provider had completed a quality enhancement plan (QEP) for the designated centre; however, on review of the most recent update completed on the 20th of July 2024, the inspectors found that the premises work had not been actioned on the QEP. Area-specific audits were being completed. It was also evident on inspection that the centre vehicles were not sufficient for meeting the collective assessed needs of residents living in the centre.

Judgment: Not compliant

## Regulation 24: Admissions and contract for the provision of services

The provider had prepared a policy for their admissions, transitions, and discharge processes that had been updated in March 2024.
Since the previous inspection, one resident had moved to another centre due to increasing medical needs, and the resident had transitioned into the centre. The inspectors reviewed the transition plans and observed that residents were informed and consulted about the planned moves and supported by family and staff in preparing for the transitions. There were lines of communication between key workers in the resident's day service and residential service to ensure actions were carried out. Compatibility assessments were also completed, and photos were taken to document the transition journey.

Judgment: Compliant

## Regulation 31: Notification of incidents

The inspectors reviewed a record of incidents that occurred in the centre over the last year and found that the person in charge had notified the Health Information and Quality Authority (HIQA) of adverse events as required under the regulations.

Judgment: Compliant

## Regulation 34: Complaints procedure

The provider had developed a complaints policy which was available and reviewed in the centre. The inspectors reviewed the complaints log for all houses in the designated centre and found that the person in charge was reviewing complaints that had been brought to their attention. However, inspectors reviewed a sample of residents' meetings and found a number of complaints in relation to the maintenance and general appearance of the premises by residents. The inspectors noted that these complaints in which residents discussed their dissatisfaction towards the general appearance of the centre had not been logged as official complaints for residents. For example, one resident complained about the staining of the kitchen area in one house and the need for interior painting in each house to provide a more homely atmosphere.
The inspectors observed that a number of complaints had been made about the premises by both residents and families, with some outstanding since 2021. The provider had yet to resolve these complaints, and no frame in place for the commencement of work had been identified.

Judgment: Not compliant

## Quality and safety

The inspector found that residents' wellbeing and welfare were maintained by a good standard of care and support in the centre. Residents appeared to be happy and content in their homes and with the service provided to them. However, improvements were required in relation to Regulation 17: premises, which included extensive refurbishment required to a number of areas in six of the houses that make up the designated centre. The inspectors found that the premises design and lay out was impacting on residents lived experience in their home with the outstanding work on the premises refurbishment taking away from a homely environment. The centre also did not meet the needs of one resident due to the busy location, which impacted the service's ability to respond to behaviours of concern safely.

The provider had a well-established risk management policy that included the arrangements for identifying, recording, investigating, and learning from serious incidents and/or adverse events involving residents. This inspection was triggered by a major incident in the centre, and the inspectors observed that, overall the provider had reviewed the incident in line with the management of incidents rated major or extreme.

The inspectors found that good practices were in place in relation to safeguarding. The provider had appropriate procedures in place, which included safeguarding training for all staff, the development of personal and intimate care plans, and support from a designated safeguarding officer within the organisation. Following a review of four residents' care plans, the inspectors observed that safeguarding measures were in place to ensure that staff who provided personal, intimate care to residents who required such assistance were in line with residents' personal plans and in a dignified manner.

Residents that required support with their behaviour had positive behaviour support plans in place. There were some restrictive practices used in this centre. The inspectors reviewed the log of restrictive practices used within the centre and found that they were subject to regular review to ensure that they were implemented in line with best practice and the least restrictive option.

## Regulation 17: Premises

The inspectors completed a walk-through of each of the seven houses that made up the designated centre. The inspectors found that there was significant work to be completed in six of the houses, the majority of which had been identified by the

provider and remained outstanding for a substantial period. The inspectors acknowledged that some of the large-scale projects required the assistance of the housing association, and this was causing a delay in the completion of the works. On the day of inspection, the following works remained outstanding:

- Upgrade of kitchens in six of the houses in the designated centres
- Upgrading of flooring in one kitchen where a leak had previously occurred and left a large majority of the flooring in the kitchen covered in a dark black stain. This piece of work had been reported by staff of the designated centre two years previously and highlighted through residents' complaints.
- The centre had five vacant bedrooms on the day of the inspection. The inspectors observed that four of the vacant bedrooms required significant repairs. The inspectors observed flooring in the bedrooms had been moved or were lifting from the floor, walls required plastering and their was rust evident on radiator and pipes.
- Four bathrooms in the designated centre had been identified for upgrades and refurbishments.
- The decor of the centre was impacted by the number of outstanding works highlighted throughout six of the houses. The centre required interior painting throughout. However, this work was not completed due to the large-scale work that was outstanding.
- Rust was observed on a number of radiators in the designated centre.
- The inspectors found that the outstanding work in the centre was impacting the homeliness, cleanliness, and overall decor of the centre. Furthermore, inspectors found that due to the changing needs of residents and the increased requirement for mobility aids, one house within the designated centre required more storage to reduce clutter and allow residents to freely access all areas of their home.

During the course of the inspection, the inspectors spoke to senior management in relation to the outstanding works in the designated centre. Inspectors discussed with management the regulatory responsibility under Regulation 17: Premises to ensure that the centre is of sound construction and kept in a good state of repair. The designated centre currently had six resident vacancies; the inspectors observed that only one of the vacant bedrooms was suitable for a resident to transition to the centre. The inspectors found that the remaining five bedrooms required significant repairs before admission could be deemed suitable for the centre.

The design and location of the centre was not suitable for one resident to ensure they lived in a safe and suitable environment that was conducive to their behavioral support needs and where their individual rights and privacy could be fully respected.

Judgment: Not compliant

## Regulation 26: Risk management procedures

A comprehensive risk register was maintained for the designated centre. The risk register accurately reflected the risks in the centre and was updated and reviewed at regular intervals due to identified changing needs in the centre. The inspector found that the risk register in place identified high-risk areas in the centre, such as residents' service experience, changing needs, emergency responses, and environmental needs.
The person in charge regularly reviewed risks presented in the centre and, in doing so, effectively identified and highlighted those risks and ensured control and mitigation arrangements were in place to manage the risks. The person in charge and senior management ensured that the identified risk had been escalated to the appropriate stakeholders and that control measures in place in the centre were the least restrictive for residents. The inspectors observed that staff were suitably informed of the risks presented in the centre and the control measures required to reduce and manage risk. The inspectors observed that the provider and person in charge had responded to emergencies in the designated centre and had ensured that residents were still promoted to enjoy meaningful activities.

The inspectors found that the risk register and risk assessments for the designated centre were subject to quarterly reviews by the person in charge, and they took into account the trend of any incidents that had occurred in the centre.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The inspectors found that there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. The provider ensured that staff had received training in managing behaviours of concern and received regular refresher training in line with best practice. Staff spoken with were knowledgeable of support plans in place, and the inspector observed positive communications and interactions between residents and staff throughout the inspection.

Three positive behaviour support plans reviewed by the inspectors were detailed, comprehensive, and developed by an appropriately qualified person. Each plan included trigger and antecedent events and proactive and preventive strategies to reduce the risk of behaviours of concern occurring.

Any restrictive practices in use in the three houses of the centre had been subject to recent review based on documents reviewed. Such review included the input of a multidisciplinary team and oversight from the restrictive practice committee.

The centre's location was negatively impacting one resident's emotional wellbeing and ability to self-regulate, which is actioned under regulation 17: Premises.

Judgment: Compliant

## Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. For example, there was a clear policy in place with supporting procedures, which clearly directed staff on what to do in the event of a safeguarding concern. In addition, all staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with were knowledgeable about their safeguarding remit.

The inspectors found that the provider had reported and responded to safeguarding concerns as required and formal safeguarding plans were in place to manage these concerns. The inspector founds that the person in charge and provider had put all measures in place to support each resident. For example, in one of the houses in the designated centre the provider had converted a vacant room for an additional sitting room to provide residents with more private space.

The inspectors reviewed three preliminary screening forms and found that any incident, allegation or suspicion of abuse was appropriately investigated in line with national policy and best practice.

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 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Not compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for DC7 OSV-0002944

## Inspection ID: MON-0044273

## Date of inspection: 12/08/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>The registered provider will 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<br><br>1. Recruitment of staff with the appropriate qualifications and skill is underway. This is an on-going action. Monthly scheduled advertisement and interviews in place. On-going timeframe Monthly 2024.<br>2. The Person in Charge will endeavor to provide continuity of care by employing consistent relief and agency staff. On-going. | |
| Regulation 21: Records | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 21: Records:<br>1. The registered provider will ensure that records in relation to each resident as specified in Schedule 3.3.n will be maintained and available for inspection by the chief inspector, specifically serious incident Preliminary Assessment Reviews completed by 30th August 24.<br>2. Rosters will be available for inspection as requested. 30th August 2024.<br>The complaints log for each location will be available for inspection as requested. 30th August 2024. | |

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
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.
1. An action plan to address outstanding minor maintenance is in place as of 27.09.24. Outstanding minor maintenance will be completed by 31.12.24.
2. A timebound action plan is in place for bathroom upgrade at 2 locations scheduled in 2024. Completion by 30.11.24.
3. Timebound schedule agreed for minor capital kitchen & bathroom upgrades for identified locations not already scheduled in 2024 in the designated centre in place for last quarter 2024, 2nd quarter 2025. Completed 27.09.24.
4. Painting and floor replacement of 5 identified bedrooms will be completed by 31.01.2025.
5. All timebound actions in relation to premises and outstanding maintenance will be placed on the designated centers QEP as of 30.09.24

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| Regulation 34: Complaints procedure | Not Compliant |

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. The registered provider will ensure that all complaints are investigated promptly in line with complaints procedure and policy and recorded on the complaints log for the designated centre. 30th August 2024.
2. The registered provider will ensure that any measures required for improvement in response to a complaint are put in place. All identified measures and actions in response to a complaint will be recorded on the complaints log for the designated centre and the QEP where appropriate. 30th August 2024

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| Regulation 17: Premises | Not Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
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 as follows:

1. Review the design and layout of current living location for one resident to provide an environment that is safe and suitable to meet their behavioural support needs in the short term. 31.12.24
2. Schedule a case review with the HSE to review and plan to meet the environment and support needs required by the resident in the long term. 31.12.24
Regulation 17(4) ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order as follows.
1. An action plan to address outstanding minor maintenance is in place as of 27.09.24. Outstanding minor maintenance will be completed by 31.12.24.
2. A timebound action plan is in place for bathroom upgrade at 2 locations scheduled in 2024. Completion by 30.11.24.
3. Timebound schedule agreed for minor capital kitchen & bathroom upgrades for identified locations not already scheduled in 2024 in the designated centre in place for last quarter 2024, 2nd quarter 2025. Completed 27.09.24.
4. Painting and floor replacement of 5 identified bedrooms will be completed by 31.01.25.
Additional storage for mobility aids for 1 location in the designated centre will be installed. 30.11.24.

## 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. | Substantially Compliant | Yellow | 12/08/2024 |
| 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 | 31/12/2024 |
| Regulation 17(4) | The registered provider shall ensure that such equipment and facilities as may be | Not Compliant | Orange | 31/01/2025 |

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| | required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents. | | | |
| Regulation 21(1)(b) | The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector. | Substantially Compliant | Yellow | 30/08/2024 |
| 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 | 31/01/2025 |
| Regulation 34(2)(b) | The registered provider shall ensure that all complaints are investigated promptly. | Not Compliant | Orange | 30/08/2024 |
| Regulation 34(2)(e) | The registered provider shall | Not Compliant | Orange | 30/08/2024 |

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| | ensure that any measures required for improvement in response to a complaint are put in place. | | | |