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:	Special Dementia Unit - Sonas Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	01 October 2024 & 02 October 2024
Centre ID:	OSV-0003746
Fieldwork ID:	MON-0044917

About the designated centre

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

The designated centre is based on a campus setting in suburban area of North-West County Dublin and provides specialist dementia care to persons with intellectual disabilities some of whom have end of life support needs. The centre is comprised of one large building which was constructed in 2013 and currently operates as two separate units within the one premises. Services are provided through 13 long term beds and one respite bed. There is a staff team of clinical nurse managers, staff nurses, care assistants and household staff employed to support residents.

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
Tuesday 1 October 2024	20:00hrs to 23:30hrs	Sarah Cronin	Lead
Wednesday 2 October 2024	10:00hrs to 15:30hrs	Sarah Cronin	Lead
Tuesday 1 October 2024	20:00hrs to 23:30hrs	Michael Keating	Support
Wednesday 2 October 2024	10:00hrs to 15:30hrs	Michael Keating	Support

What residents told us and what inspectors observed

From what residents told us and what inspectors observed, it was evident that residents living in this designated centre were well cared for. They were engaging in meaningful activities and receiving person-centred care. However, the inspection found mixed levels of compliance with the regulations. While there were good practices were found in areas such as individualised assessments and personal plans, improvements were required in governance and management, staffing and staff training and development. These are discussed in the body of the report.

This designated centre is a purpose-built unit for residents who have an intellectual disability and a diagnosis of dementia. It is based on a campus in Dublin. The centre is divided into two units. Willow view is an eight bedded unit for people living with dementia. One resident had a self-contained apartment within the centre. The second unit, Meadow view provides specialised advanced dementia up to and including end-of-life care. The building was well suited to residents' assessed needs. Each resident had their own bedroom and en-suite bathroom. Tracking hoists are available in some of the rooms and the building is wheelchair accessible throughout. There are two large kitchen and dining areas. The centre has an internal courtyard which is accessible from both units. The centre had been recently reconfigured to enable residents have more spaces to spend time in, which included having an office for a resident and an additional sitting room. The centre was beautifully decorated, with large colour photographs of residents, past and present, on the walls. Each residents' room was personalised in line with their life story. For example, for one resident who had worked in a library, staff members had sourced lighting and wall paper of books in line with that residents' interests. Another resident who enjoyed sorting papers now had their own office with papers to sort and a telephone.

The inspection focussed on safeguarding of residents and the inspectors visited the centre at night-time and continued the inspection the following morning. Inspectors met with nine members of staff and all of the twelve residents over the course of the inspection. Residents were at varying stages of their dementia journeys, and many of the residents presented with complex communication needs. This meant that they communicated using eye contact, facial expressions, body language, vocalisations and some speech. One resident had a large board outside of their room with the date and time and their activities each day to orient them to what was happening in a consistent way. Other residents had life story books and/ or communication passports and guidance in their care plans. Interactions which the inspectors observed between staff and resident were found to be friendly, respectful and kind.

On arrival to the centre in the evening, inspectors found that all of the residents were going about their bed-time routines. Some residents were in bed, while others were in their wheelchairs. Residents were listening to music or watching television. There was soft music playing for some residents and soft lighting. This created a calming atmosphere. One of the residents greeted the inspector and showed them

their new office space. They also showed an inspector their bedroom, which was highly personalised and had medals from the Special Olympics and photographs of people who were important to them. They told the inspector that things were "great" and appeared to be comfortable and content in the company of staff during the night and by day. They were observed freely walking around the unit and asking staff about their plans, and staff on duty. Since the last inspection, the resident had had a number of overnight stays in hotels in line with their wishes, and were supported to access local barbers, coffee shops etc with staff. Residents were all well-presented and appeared to be comfortable and content. Staff told inspectors that many of the residents had attended a party that day. Another lady was sitting up smiling and laughing in response to interactions. One inspector had the opportunity to sit with a resident in their own living space. The resident was observed interacting with staff, who was familiar with their communication support needs, and who was noted to respond to all of their requests.

In the morning and throughout the afternoon on the second day, inspectors found that residents were supported with care routines in a kind and compassionate manner. For example, inspectors observed residents receiving food and drink and staff were noted to sit at eye level and engage in chat. One resident was observed watching their favourite band on television and clapping along. They asked a staff member to dance with them and this was observed to be happy and relaxed. Other residents were supported to access activities in the day service on the campus.

Residents' care plans had a 'menu of life enhancing activities' in place to promote residents engaging in meaningful activities. Some of the options on these menus included going to mass, going for walks, accessing the day service, reflexology, sensory activities such as hand massage. One inspector had the opportunity to sit with a staff member who showed them a person-centred plan which they had prepared in an accessible format using photographs and pictures. They had completed work on the resident's life story and spoke about the resident's goals. They spoke about a resident who had previously enjoyed swimming, and how they had now ensured that they enjoyed a bath in a parker bath regularly.

In summary, inspectors found that residents appeared to be well cared for and content in the company of staff. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

This was an unannounced risk-based inspection which took place following receipt of solicited and unsolicited information related to safeguarding. There had been a high level of notifications relating to peer-to-peer incidents in the centre received over the past eighteen months. A provider assurance report had been sought in July

2023, and this gave assurances to the Chief Inspector on measures which the provider was taking to safeguard residents. A second provider assurance report was sought in July 2024, and this gave further assurances on increasing staffing, and re purposing some rooms in the centre to enable residents have more space to spend alone where they wished to do so. Unsolicited information was received in September 2024 which raised concerns related to safeguarding and staffing arrangements at night-time, and this information prompted this inspection. The inspection took place over two days. Inspectors visited the centre at 9pm, where they met with residents and staff. They returned the following morning. As outlined at the beginning of the report, inspectors found mixed levels of compliance with the regulations, with improvements required in staffing, training and staff development and governance and management.

Inspectors found that while the management arrangements were effectively monitoring and overseeing residents' care and support by day time, the management structures and systems for night-time were found to be ineffective. For example, staff on duty on the evening of the inspection were not clear on who the person in charge was, or what the lines of reporting were. Inspectors found that there were senior management meetings during the day, and that these covered a number of key service areas including staffing, safeguarding, incidents and accidents, however, night managers were not required to attend these, nor was there evidence of night management meetings provided. Night managers told inspectors that they communicated with the person in charge via email. Similarly, night staff were not required to attend staff meetings in the centre.

Due to a high number of vacancies, and sick leave in the centre, there was a high reliance upon agency and relief staff. Staffing was identified as a challenge by the provider on a number of audits, and there was evidence that it was regularly discussed at management meetings. The provider gave written assurances to inspectors on a recent recruitment day which had successfully recruited new staff. They were due to be inducted in the following month. However, the current staffing arrangements in the centre were found to be having a negative impact upon residents' continuity of care. This is further discussed under Regulation 15: Staffing below.

Staff had been provided with training and education to ensure that they had the required knowledge and skills to best meet residents' assessed needs. However, supervision arrangements in place were not adequate to ensure that the entire staff team were appropriately supervised in their roles. Information provided to inspectors suggested that staff were sleeping on shift at night time. Staff and management reported that the practice was that staff could sleep for their break time while on shift, and that they did so in their cars or in the centre itself. However, given the supervision arrangements and management attending the centre at relatively set times each night, inspectors could not be fully assured about the safety of this practice.This is discussed under Regulation 16: Training and Staff development below.

Regulation 15: Staffing

Inspectors found that the staffing arrangements in the centre were not effective to enable residents to enjoy continuity of care. There were a number of vacancies at the time of the inspection. The provider had recently recruited to a number of these posts, and staff were due to commence in the organisation in the month following the inspection. However, the provider was heavily reliant on relief and agency staff to ensure that there was an appropriate number of staff on duty each day. This meant that residents were not always receiving continuity of care. All of the staff who inspectors had spoken with referred to staffing and consistency of staffing being a significant challenge for them. A number of staff spoke about the negative impact of unfamiliar staff on some residents, which had led to some incidents relating to behaviours or upset. Communication with unfamiliar staff was also reported to be an issue leading to communication breakdown.

Inspectors viewed a sample of eight weeks of rosters. Some staff working in the centre worked permanent night shifts, and therefore did not attend staff meetings, and had a different supervision structure than day staff. From the review of rosters, inspectors found that while there were an adequate number of staff on duty by day and by night, there were a high number of agency staff being used. For example, in August, there had been a total of 47 staff covering vacant shifts. 22% of day shifts were covered by relief staff, 70% were covered by agency, and the remainder were filled by regular staff doing additional shifts. In the same month, 25% of night shifts were covered by relief staff and 35% were agency staff.

In September, there had been a total of 53 different staff covering vacant shifts. 16% of day time shifts were covered by relief staff, 80% were filled by agency staff and 4% by regular staff. 43% of night shifts had been covered by relief staff, 43% were agency and the remainder were regular staff.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors viewed the staff training matrix and found that staff had received training in key areas of service provision such as dementia, feeding eating, drinking and swallowing, safeguarding and manual handling. However, the arrangements for staff supervision required review.

Inspectors spoke with staff and management by day and night about their supervision arrangements and found that staff supervision was not occuring in line with policy, or with the due dates recorded on minutes of supervisions. They found that the provider and the person in charge had limited oversight of night-time staffing arrangements. For example, some staff members spoken to were unaware of who the person in charge of the centre was, or were not aware of formal

supervision arrangements. The night manager was responsible for the formal supervision of night-time staff. There was a supervision agreement in place for nursing staff working at night time stating that they would meet three times a year. However, records viewed by inspectors noted that only one meeting was documented and available to review . Similarly, there was an agreement between a health care assistant and the night manager for supervision to take place 3/4 times per year. Again, there was only one record for 2024 available. For some night staff, no records were provided to the inspectors and therefore it was unclear whether these had occured or not.

Information provided to inspectors suggested staff were sleeping on shift. However, in discussions with staff, inspectors were informed that the practice was to sleep during break times. Night managers were reported to visit the unit at roughly the same times between once and twice a night, or more if it was required. This meant that management could not be fully assured that staff were awake when they were on duty each night outside of their break times, and that the current supervision arrangements in place were adequate to monitor practices on a day-to-day basis.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that while there was clear lines of authority and accountability, there was not a clear linkage of the service by day and night to ensure that residents' care and support was delivered in a safe and consistent manner. This was further compounded by high use of relief and agency staff. For example, there were regular meetings of management on the campus. Minutes demonstrated that night managers were not in attendance at these meetings. Similarly, inspectors viewed records of a sample of three staff meetings which had taken place. No night staff had attended any of these meetings. This meant that day and night staff were operating somewhat separately, and this had the potential to have a negative impact on residents' care and support.

Discussions with staff on duty the night of the inspection showed that staff were aware of their safeguarding responsibilities, but they were not familiar with the management structure and key personnel , which meant that their understanding of roles and responsibilities, and the reporting structure was not accurate. Some staff members who inspectors spoke with reported that they would raise any concerns they had with management, while others reported that outside of immediate risk and safeguarding, that they would not discuss other concerns. There were handover arrangements in place between nursing staff. However, care staff reported that they were not involved in these handovers which meant that they did not always get a full 'picture' of all of the residents.

The person in charge had been absent for an extended period of time on the day of the inspection. A clinical nurse manager, who also had a management role across

the campus, was the person in charge of the centre. They were based in an office on another part of the campus, and were in touch with the centre a number of times each day. They were supported in their role by a clinical nurse specialist who was temporarily filling the role of a clinical nurse manager. However, they reported that they were due to cease this post the week of the inspection.

Inspectors viewed a record of audits taking place in the centre in addition to the provider's six-monthly unannounced provider visits. These indicated that while there were actions identified, these were not always actioned as required. The person in charge and person participating in management met regularly, however these were not all documented. One meeting record was viewed by inspectors and found to lack detail on discussions which did not give inspectors assurances that the centre was being effectively monitored.

As discussed under Regulation 16 above, the provider had not ensured that there were effective arrangements in place to support, develop and performance manage all members of the workforce to ensure that staff could raise concerns about the quality and safety of residents could be raised.

Judgment: Not compliant

Quality and safety

Inspectors found that in spite of areas of concern relating to staffing, training and staff development, and governance and management, there was observational and documented evidence that residents were well cared for and supported in the designated centre. Inspectors observed residents on both days and found them to be well presented and content, and supported in a dignified manner with activities of daily living such as mealtimes and bed time routines. Residents in the centre were receiving dementia-specific care, and the centre was regularly attended by clinical nurse specialists in dementia and other health and social care professionals.

Residents in the centre had assessments of need and associated care and support plans which were aligned to dementia care standards (McCarron, M. and Reilly, E., 2010). Inspectors found that residents' care and support plans were easy to follow, and written in a person-centred way. Each of the plans viewed by inspectors had documented residents' life stories and clearly outlines their hierarchy of needs. Residents had access to a range of health and social care professionals including speech and language therapy, physiotherapy and occupational therapy.

Residents who required positive behaviour support plans had these in place, and these also considered the impact of any behaviours of concern or distress on other residents. Residents' communication support needs were found to be well documented and promoted residents' right to communicate , and right to choose their daily routines.

This report had a specific focus on safeguarding. Inspectors found that the provider had put a number of measures in place to reduce peer-to-peer incidents, and to ensure that all staff were trained, and that they were aware of their reporting obligations. Inspectors observed that all staff were knowledgeable on safeguarding plans in the centre.

The premises was found to be in a good state of repair, clean and well suited to residents' assessed needs. The provider had risk management systems in place to identify, assess and mitigate against risk in the centre, including a system for for responding to emergencies.

Regulation 10: Communication

From a review of four care plans, and from observations, it was evident that each residents' life stories, will and preferences were used to enhance communication in the centre. Some residents were able to communicate verbally, while others relied upon staff to know them well in order to respond to their communication.

On both days of the inspection, inspectors saw that communication of all forms was respected and responded to. Inspectors saw kind and caring interactions between residents and staff, and staff were able to use their knowledge of residents and their routines to elicit responses. There were communication care plans in place. These outlined strategies for staff to use to promote effective communication with residents, including positioning, eye contact and overall presentation. Residents had their own tablet devices to use to put on preferred music or to look at photographs, which were reported to prompted interactions.

Residents' care plans demonstrated that there was clear documentation about how to recognise pain for each of the residents, and this information was also used in their hospital passports. From a safeguarding perspective, residents had access to easy to read information on safeguarding. However, due to the complex communication needs of many residents, they relied upon staff to advocate for them and raise concerns where required. As outlined in Regulation 8: Protection, inspectors were assured that staff were well informed on both communication and safeguarding plans in the centre, and there was evidence that they were reporting incidents to ensure that residents were supported. Safeguarding documentation reviewed noted that reports referred to how residents communicated, and this was used to inform plans.

Judgment: Compliant

Regulation 17: Premises

Inspectors did a walk about of the centre on both days. It was clean and warm and

found to be well suited to residents needs. The environment had been purpose built for residents with dementia, and enabled residents to go in and out of a sensory garden which was at the centre of the unit. Each resident had their own en suite bathroom, and rooms were adapted to suit residents' needs. For example, ceiling hoists were available, along with an accessible parker bath. Bedrooms were beautifully decorated, and consideration had been given to residents' preferences and life stories. Since the last inspection, the provider had re-purposed some rooms in the centre to enable residents to have spaces to spend time in alone where they wished to do so as part of a centre-specific safeguarding plan.

Judgment: Compliant

Regulation 26: Risk management procedures

Inspectors found that the provider had taken a proactive approach to risk management in the centre. Inspectors viewed the location-specific safety statement and risk register in place in addition to risk assessments for four residents. Risk assessments were in place for each resident in line with their assessed needs in areas such as manual handling, choking, absconscion, bruising and skin integrity. Inspectors found that risks related to manual handling had been carefully considered, and that plans were in place for the use of bed rails, the use of wedges, and the use of specific beds to ensure that residents' safety was maintained at all times.

Inspectors reviewed incidents and accidents which had occured in the centre in the months prior to the inspection taking place. Incidents and accidents were trended every quarter for each resident, in addition to being trended for the centre. Learning from adverse incidents was shared with the staff via a safety pause at handover and at staff meetings. However, as outlined above, this required improvement to ensure that this was communicated with all staff. This is discussed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inspectors viewed a sample of four residents' assessments of need and associated care and support pans. Inspectors found care plans were well laid out and easy to follow, with a focus on residents' life stories and background. Assessments of need and care plans promoted the rights, health, wellbeing and safety of residents. There was a hierarchy of needs at the front of the care plan which ensured that key information was easily accessible to staff. Residents had personal plans in place, with goals which included items such as publishing written stories, going to church,

overnight stays in hotels and enjoying alternative therapies such as reflexology on a regular basis. Advance care plans were also in place for some residents.

As outlined in the opening section of the report, inspectors found that staff had put significant time into creating meaningful person-centred plans for residents, and that they had used information on residents' past will and preferences to inform their current care. For example, for one resident who was distressed by the shower, staff had noted that they previously enjoyed swimming. They trialled the resident using a parker bath, and they reported that they now enjoyed bathing regularly.

Safeguarding risks and needs were identified in residents' care plans, and measures were in place as part of the care planning process.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were a small number of residents who had positive behaviour support plans in place. Inspectors viewed two of these plans and found that they outlined proactive and reactive strategies for staff to use including creating a low arousal environment. Inspectors observed a calm and quiet environment on both days of the inspection. There was a grading system in place to support staff to make decisions to ensure that they were responding consistently to the resident up to and including administration of pro re nata (PRN) medication. There was a clear protocol in place for the use of PRN medication, which included getting permission to do so from senior management. Staff on both shifts demonstrated that they were familiar with the traffic light system in place and mood charts to best support residents. Risk assessments were also in place related to behaviours, and there were measures in place to uphold safeguarding needs of other residents where this was required.

There were some restrictive practices in place in the centre which were prescribed by members of the multidisciplinary team. A review of quarterly notifications, and the restrictive practice log found, for example, that some doors required a swipe to access parts of the centre, some residents required bed rails, others required lap belts on wheelchairs or comfort chairs. These were regularly reviewed. There was easy to read information available for staff to use with residents to explain practices in place in the centre.

Judgment: Compliant

Regulation 8: Protection

Inspectors reviewed the twenty four notifications which were submitted to the Office

of the Chief inspector over the past twelve months. Inspectors viewed the safeguarding log, and preliminary screening forms for notifications received and found that there were safeguarding plans in place, in agreement with the HSE safeguarding and protection team.

The provider had taken a number of actions to enhance safeguarding measures in the centre which included increasing staff numbers, ensuring a holistic review of residents' health was regularly carried out and re purposing areas of the centre to enable one resident to live in their own apartment, and to allow others spend time alone in quiet spaces outside of their bedroom. Inspectors viewed a sample of three sets of minutes from weekly safeguarding meetings and noted that these covered any incidents which had occured that week, inputs which were required for residents and any additional measures were documented. It was evident from the minutes that the provider identified areas for improvement or learning following each incident. Meetings were attended by advance nurse practitioners, staff members, management and members of the multidisciplinary team. Safeguarding audits had been carried out every three months to identify any specific trends, and to put actions in place. This included the need for regular medical checks and input from the clinical nurse specialist in behaviour.

Staff who inspectors spoke with by day, and by night were aware of active safeguarding plans in the centre, they had received safeguarding training, and they were able to describe actions they would take where they had any concerns. A review of four residents' care plans related to personal and intimate care were viewed. These were found to be detailed to guide staff 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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Special Dementia Unit - Sonas Residential Service OSV-0003746

Inspection ID: MON-0044917

Date of inspection: 01/10/2024 & 02/10/2024

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: Service Manager has secured permanent CNM2/PIC to commence November 13th, 2024. Full complement of Staff Nurse has been secured. Care Staff x 1 has commenced since inspection, outstanding vacancies currently under recruitment and HR process. Regular relief and agency staff are secured where possible to ensure effective arrangements and continuity of care are in place to support delivery of quality of care.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Supervision schedules have been put in place to ensure supervision is in line with policy for all staff. Supervision records for all staff will be available on site. Workshops are scheduled to commence 6th Nov 2024 to provide information to Managers and staff in relation to formal supervision and governance structures in the centre. The organization's Supervision policy has been furnished to the designated center to ensure all staff are knowledgeable re formal supervision. Night Managers are requested to sign in on site on each visit to the designated center. Night Managers will vary visitation times. An Audit will be conducted monthly by PPIM and PIC to ensure governance re same. Night Managers are to provide governance on Night Duty to ensure all staff are alert and awake when on rostered duty. Night staff have been made aware of break allocation times, roles, and responsibilities. Night Staff have been given information on how to raise any concern they may have .	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Night managers' meetings will be scheduled every two months with the Service Manager. Night managers are also invited to attend local manager meetings. Invitation to attend all local meetings will be extended to night staff. Handover procedures for night duty staff are under review to ensure all staff are provided with knowledge and information on all residents to support safe and effective care. KPI's are being developed for Night Mangers and once agreed they will be commenced. All staff day/night, required to read and sign all minutes for scheduled meetings in designated area. These will be reviewed by PIC/PPIM during monthly meetings to ensure staff have read and signed same. All night staff are to attend Information sessions with social workers to ensure they are aware of their roles and responsibilities and reporting structures for safeguarding. Safeguarding flowchart has also been implemented to assist staff which outlines steps to be taken in the event a safeguarding concern has been raised. All staff have been provided with the policies aimed at guiding and supporting them if they wish to raise a concern to ensure quality and safety for all residents. Information has also been circulated in relation to: • Support contact persons available for the center and the organization. • Designated complaints officer • Confidential recipient • Employee assist program All audits in the center with be reviewed and actioned in accordance with the audit schedule. PPIM and PIC governance meetings will be detailed and completed monthly in line with PPIM KPI. Permanent PIC/CNM2 was recruited to ensure governance and effective arrangements in place to oversee the Centre. Weekly governance meetings continue in the center whereby Service Manager or deputy are in attendance in conjunction with MDT Members and continue to raise awareness of a concern within the designated Centre. These meetings are recorded, and minutes are shared with night staff who must read and sign them.	

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	28/02/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	31/01/2025

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	31/01/2025
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/01/2025
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/01/2025