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:	Ard na Greine
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	23 June 2022
Centre ID:	OSV-0001689
Fieldwork ID:	MON-0033714

About the designated centre

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

Ard Na Greine is a designated centre operated by Sunbeam House Services Company Limited by Guarantee. The centre provides residential services to people who are fully ambulant, with moderate support needs. Residents are encouraged and supported to live as independently as possible within their local community. The designated centre can provide for a maximum of four adults with intellectual disabilities, of mixed gender who are over the age of 18 years. This designated centre was originally two houses that have been combined to become a large home with six bedrooms. The ground floor comprises a kitchen, sitting/dining room, a bedroom with en-suite bathroom and a utility room. Upstairs has four bedrooms, one sitting room, an office and two bathrooms. There is an enclosed garden space to the rear of the property. The staff team consists of social care workers and is managed by a full-time person in charge, with support of a senior manager. The person in charge is also responsible for another designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 23 June 2022	09:45hrs to 19:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

On the day of the inspection, the inspector met with the three residents living in the centre. Conversations between the inspector and the three residents took place, as much as possible, from a two metre distance, wearing the appropriate personal protective equipment in adherence with national guidance.

While the inspector met with all three residents, some residents spoke in more detail about their lived experience in the centre that others. Some residents relayed their unhappiness about their lived experiences in the centre and how it was impacting on them in a negative way. The inspector found, through conversations with residents, that not all residents felt comfortable living in the house and at times were anxious and afraid to be in the same room as other residents. In addition, not all residents were happy living in the house and wanted to move out of it as they did not like living with other people and wanted to live on their own.

The inspector observed the house to be clean and in good upkeep and repair. The provider had recently completed an upgrade on the house. The walls were freshly painted, there was new furnishings, flooring and facilities provided as part of the upgrade. Residents' bedrooms had also being provided with an upgrade. Residents were happy to show the inspector their bedrooms. Overall, the inspector observed that residents expressed themselves through their personalised living spaces and had been consulted in the décor of their rooms which included family photographs, paintings and memorabilia that were of interest and meaningful to them.

On speaking with residents and staff, and on review of documentation, the inspector saw that residents were supported to engage in a variety of activities in the community. For example, through employment, through community day services and through attending community activities within the in-house day service provided to residents during the week. Some of the recent activities included attending concerts, both in Ireland and abroad and organising and attending milestone birthdays with friends and family. In line with residents likes, interests and in some cases, goals, residents were involved in a number of household tasks such as cleaning, laundry and cooking.

Families played an important part in the residents' lives. Management and staff acknowledged and supported these relationships and supported residents keep regular contact with their families and in particular, during the health pandemic restrictions, family contact was maintained in a way that supported the health, safety and wellbeing of the residents.

Through-out the day, the inspector observed there to be positive engagements between the residents and staff. Staff were caring and respectful when speaking with the residents and appeared to understand what residents were communicating to them. Where appropriate, and in particular, regarding compatibility issues in the house, staff advocated on behalf of residents and supported residents to make a

complaint about matters they were unhappy about.

Residents were provided with information, such as easy-to-read information, to assist them to understand the centre's complaints' policy and procedures. On review of the complaints log, the inspector found that there had been a small number complaints logged by residents, some which related to living arrangements and some relating to the impact behavioural incidents in the house had on them. On speaking with residents, not all residents had felt comfortable making complaints in the past.

In summary, the inspector found that overall, through speaking with the residents and staff, through observations and a review of documentation, it was evident that the person in charge and staff were endeavouring to make sure that residents were supported to be included in their community as independently as they were capable of. However, overall, the inspector found that, residents lived experience in the designated centre was not always positive. This was due to the on-going compatibility issues in the house and that the service was not meeting the assessed needs of all residents, at all times.

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

Capacity and capability

The inspector found that management systems in place did not adequately ensure that the service provided was safe, appropriate to the residents' needs and effectively monitored, at all times. There was a significant increase of non-compliance found on this inspection compared to the last inspection in January 2021. For example, the provider had not complied with regulations relating to protection, admissions, governance and management and notifications of incidents, and a number of actions were required to bring them back into compliance. Overall, the inspector found that, the provider was not operating the centre in a manner that ensured residents were living in an environment that met their assessed needs, at all times.

There were compatibility issues in the centre that resulted in behavioural incidents which impacted negatively on the lives of the residents, and had resulted in residents feeling unsafe in their own home and when out in the community. There were safeguarding plans in place to try reduce the occurrence of incidents, however, the provider had not ensured that the plans were always available to staff or that they had been reviewed monthly as per the action on the safeguarding plan. In addition, not all residents felt they were living in a suitable environment that met their needs and in particular, in relation to independent needs. While there was a referrals committee established in the organisation to support residents relocate to

services that better met their needs, there was a waiting list which meant there was long delays for residents waiting to move.

There was a new person in charge employed in the centre in February 2022 and a new person participating in management commenced their role in December 2021. On the day of the inspection, the person in charge was not available to support the inspection. Staff members on duty supported the inspection as much as they had the capacity to, however, through-out the day, they were needed on numerous occasions to support residents with planned appointments and activities. The person participating in management was available for some of the day to support the inspection. The quality complaint manager also assisted with gathering some of the required information. However, there were a number of documents and information that could not be easily accessed through-out the day by the staff or senior management. Overall, the arrangements in place, when the person in charge was absent, required review. In particular, to ensure that information and procedures, which related to the general welfare and protection of the residents, was available to all staff, at all times. This was to ensure that, in the absence of the person in charge, the service provided to the residents was safe and effective, particularly in relation to residents' personal plans and guidance pertaining to safeguarding.

The provider had submitted an application to vary to add another designated centre to this designated centre in March 2022. The model of care and support delivered to residents in this designated centre, as described in the statement of purpose, was different to the model provided in the other centre. Overall, the inspector found that the governance and management systems in place in this centre did not always ensure that the service was safe or meeting the needs of residents. As such, the addition of another centre could potentially increase the risk of further negative impacts to residents' lives and increased levels of non-compliance found on the day of the inspection.

The governance and management quality assurance systems in place were not effective, at all times. The annual review of the quality and safety of the care and support provided in the centre for 2020 and 2021 was not available to the inspector or to residents and their families on the day of the inspection. On review of the six monthly unannounced review action plan and the 2021 annual review (that was subsequently submitted to HIQA), the inspector found that they were not in line with the regulatory requirement. For example, they included the review of the quality and safety of care and support provided to a resident in another designated centre.

The provider had not ensured, at all times, that all applications for admission to the designated centre were determined on the basis of transparent criteria in accordance with the statement of purpose and in particular, in relation to emergency admissions. Not all residents' personal plans included a compatibility assessment in advance of them moving into the centre. As a result, the provider could not be assured that the service met the needs' of residents moving into the centre or that all residents were protected from all forms of abuse. The impact of this meant that residents likes and dislikes, such as they type of environment the service provided, the needs and supports of other residents living in the centre, was

not always taken into consideration.

The inspector reviewed a sample of staff rosters and found that, for the most part, staffing arrangements included enough staff to meet the needs of the residents. However, on the day of the inspection, the inspector found that the number of staff employed in the centre was not in line with the statement of purpose. On review of the roster, the inspector found that the roster was not maintained appropriately at all times. While the person in charge was endeavouring to ensure continuity of care, the regular dependence on agency and relief staff, at times, impacted on the effectiveness of the continuity of care provided to residents.

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained. A training matrix was maintained by the person in charge, which demonstrated that staff were provided with both mandatory and refresher training. However, on the day of inspection, the inspector found that some staff refresher training courses were overdue.

Regulation 14: Persons in charge

The person in charge divided their role between this centre and one other. On review of the notification submitted, 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. However, in light of the significant increase in non-compliance in the centre, a review of the person in charge's capacity to divide their time between two centres was needed. This was to ensure the effective governance, operational management and administration of the designated centres concerned at all times.

Judgment: Substantially compliant

Regulation 15: Staffing

The number of staff employed in the centre was not in line with the centre's statement of purpose. There was one staff vacancy. In addition, cover was required for staff who were on extended leave. For the most part, agency and relief staff were employed to cover gaps in the roster. At times, this impacted on the continuity of care for residents.

The roster was not maintained appropriately at all times. For example, the roster did not clearly identify staff who were employed on less than a full-times basis, such as relief or agency staff. In addition, where agency staff had been employed, their full name was not always included on the roster. Furthermore, there had been occasions where no name was included where an agency staff had been employed.

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 however, a number of staff refresher training courses were overdue. For example, refresher courses in training related to managing behaviours that challenge and restrictive practice.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, the inspector found that, the provider was not operating the centre in a manner that ensured residents were living in an environment that met their assessed needs, at all times.The governance and management systems in place in the designated centre did not ensure, at all times, that the service provided was safe, appropriate to all residents' needs and effectively monitored. For example, compatibility issues in the centre were impacting negatively on the lived experience of residents, including residents feeling unsafe in their own home and when out in the community. In addition, not all residents felt they were living in a suitable environment that met their needs.

Some of the arrangements in place, when the person in charge was absent, required review. In particular, to ensure that information and procedures, which related to the general welfare and protection of the residents, was available to all staff, at all times. For example, on the day of the inspection the person is charge, who was out absent, needed to be contacted by the person participating in management on several occasions to locate documentation that related to the quality of care and support provided to residents.

The inspector found that the governance and management quality assurance systems in place were not effective, at all times. For example, not all annual reviews were made available to the inspector or to residents and their families.On the day of the inspection, the annual review available in the centre was regarding the quality of care and support provided to residents during 2019.

There were a number of anomalies with the designated centre's 2021 annual report. For example, the report was dated December 2022. In addition, the report was not specific to this designated centre as it included a review of another designated centre, which it stated was now part of the designated centre (the centre related to the application to vary that had not yet been completed). The unannounced six monthly review of the quality and safety of care and support provided to residents in

the centre also included a review of another centre in the report, including the associated actions.

The provider had not ensured that all emergency admissions were in line with the centre's statement of purpose's admission criteria and organisation's referral policy and in particular in relation to emergency admissions. As a result, the provider could not be assured that the service met the needs' of all residents moving into the centre and that residents were protected from all forms of abuse.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspector found that where there had been emergency admissions, residents had not always been provided with a a compatibility assessment to ensure the centre met their assessed needs and that all residents living in the centre were protected from all forms of abuse. For example, behaviour incidents often resulted in loud shouting and noise in the house which was in contraction to some residents assessed needs, likes and preferences.

All residents had been provided with a written agreement regarding the terms on which that resident shall reside in the designated centre however, not all residents' agreements included sufficient evidence to demonstrate that they had understood and were satisfied with the agreement.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found that improvements were needed to the information governance arrangements in place to ensure that the designated centre complied with notification requirements. For example, not all incidents were notified as appropriate to the Office of the Chief Inspector in line with Regulation 31. For example, where safeguarding incidents had occurred, not all were notified to HIQA as required. Overall, a review of all incidents was needed to ensure, that where they met the threshold, they were notified to the Health Information and Quality Authority (HIQA) as required.

Judgment: Not compliant

Quality and safety

The person in charge and staff were endeavouring to provide care and support to empower residents live a good life and to live as independently as they were capable of. However, due to on-going compatibility issues in the house, residents lived experience was not always positive, both within their home and in the community. The inspector found that the governance and management arrangements, to support the delivery of a quality and safe service in the centre, were not always effective. As a result, there was an ongoing risk to the health, safety and well-being of residents living in the designated centre.

Residents were assisted and supported to develop the knowledge, self-awareness and, understanding and skills, needed for self-care and protection. Each resident was provided with an easy-to-read safeguarding passport which included information on the different forms of abuse and how to keep safe. However, the inspector found that the impact of ongoing behavioural incidents occurring in the centre, a number of which included loud and prolonged shouting, had resulted in negative outcomes for some residents. When speaking with the residents, the inspector found that not all residents liked living in a house with other people and wanted to live on their own. In addition, not all residents were happy with who they were sharing their home with.

Overall, the inspector found, that while the current living arrangements were in place, the risk of continued behavioural incidents remained, and as such, the provider could not be assured that residents were protected from all forms of abuse, at all times. Although the provider had implemented strategies in an effort to try and reduce the compatibility issues in the house, such as monitoring residents in communal areas and providing an additional sitting room to one resident, the overall impact of the incidents meant that not all residents' assessed needs were being met at all times.

There were support plans, risk assessments and where appropriate, positive behavioural support plans in place however, due to the on-going nature of behavioural incidents in the house (and community), a review of the plans was required. This was to ensure there on-going effectiveness. On the day of the inspection, residents who spoke with the inspector were feeling anxious or fearful about the on-going incidents occurring in the house and said they had been for some time. Some residents had made complaints about how stressful the situation was. Staff had also relayed their concerns about the impact on-going behavioural incidents were having on the residents, both in the house and the community.

Where there were safeguarding plans in place for residents, they were not always updated as per the action on the plan. In addition, the safeguarding plans were not always easily available to staff (or to the inspector on the day of inspection). Staff who spoke with the inspector were aware of how to support the residents however, as safeguarding plans were not easily available to staff, there was a potential risk that not all staff working in the centre, and in particular, staff who were not employed on a full-time or permanent basis, would be knowledgeable and aware of

the measures in place to keep residents safe.

In addition, from a review of residents' daily notes, adverse incident reports and from speaking with the residents and staff, the inspector found that not all safeguarding incidents had been reported in line with the national safeguarding policy and procedures. Furthermore, on review of the recording of adverse incidents, the inspector found that improvements were needed to ensure that the reports clearly included the impact behavioural incidents had on all residents who were involved in, or witness to, the incident.

In September 2021, the residents moved out of the house to accommodate a significant upgrade to the premises. They returned to the house in February 2022. The physical environment of the house was bright and clean and in good decorative and structural repair. The design and layout of the premises endeavoured to ensure that each resident lived in an accessible, comfortable and homely environment. This was in an effort to promote independence, recreation and leisure in the house. Residents expressed themselves through their personalised living spaces and had been consulted in the décor of their rooms which included family photographs, paintings and memorabilia that were of interest to them. Residents were happy to show the inspector their rooms and for the most part, appeared proud to show off their room and the contents within it. In an effort to try reduce compatibility issues, a second sitting room was included upstairs. This was to support residents have time out alone and to relax in individual and communal spaces.

On review of the centre's risk register, the inspector found that the register did not include all identified risks in the centre. The inspector also found that where there were risks identified on the register, in some cases, the risk had not been included in correlating documentation, including residents' personal plan.

Policies and procedures and guidelines in place in the centre that related to infection prevention and control were detailed in nature and clearly guided staff to prevent or minimise the occurrence of healthcare-associated infections. The inspector observed that staff were engaging in safe practices related to reducing the risks associated with COVID-19 when delivering care and support to the residents. However, in addition, improvements were needed to some of the facilities that were provided in shared bathrooms to ensure the safety of all residents and to reduce the risk of the spread of health-associated infectious deceases.

The inspector found that overall, there were appropriate systems in place for the prevention and detection of fire. For the most part, staff had received suitable training in fire prevention and emergency procedures firefighting equipment. Fire alarm systems were appropriately serviced. There were means of escape, including emergency lighting. Fire safety checks took place regularly and were recorded appropriately. Fire drills were taking place at suitable intervals. However, improvements were needed to ensure that there was adequate provision made for all residents' safe evacuation, from the centre, at all times.

In addition, improvements were needed to the fire alarm panel system to ensure, that in the case of a fire, staff were able to identify where the fire might be.

Furthermore, where the health and safety audit (completed in April 2022), had identified that staff required training on the fire alarm system and that a mechanical arm was required for the kitchen door, with the latter being noted as urgent, neither action had been completed and there was no plan or time-line in place for them to be completed. The delay in completing these tasks meant that there was a potential increased risk to the health and safety of residents living in the centre.

Regulation 17: Premises

There had been an major upgrade to the premises since the last inspection in January 2021. The physical environment of the house was bright and clean and in good decorative and structural repair. The design and layout of the premises ensured that each resident lived in an accessible and comfortably environment. Residents expressed themselves through their personalised living spaces and had been consulted in the décor of their rooms which included family photographs, paintings and memorabilia that were of interest to them.

Judgment: Compliant

Regulation 26: Risk management procedures

The centre's risk register did not include all identified risks in the centre. In most cases, there were risk assessments in place for the risks however, they had not been included on the centre's register.

In addition, where there were risks identified on the register, in some cases, the risk had not been included in correlating documentation, including residents' personal plan. For example, where there was a risk that a resident might not self-isolate during an outbreak of COVID-19, this has not been included in their self-isolation plan or risk assessment.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Residents were supported to be knowledgeable and educated in matters relating to the current health pandemic and how to keep themselves safe including information on the vaccination process.

However, while all residents were provided with self-isolation plans in the case of a breakout of an infectious decease in the centre, some plans and associated risk

assessments, required reviewing to ensure they were in line with risks identified on the centres risk register. In addition, a review of the hand-drying facilities in two of the shared bathrooms was required to ensure the safety of all residents using the facilities and to reduce the risk of the spread of health-associated infectious deceases.

Some residents' self-isolation plans and associated risk assessments, required reviewing to ensure they were in line with risks identified on the centres risk register.

In addition, a review of the hand-drying facilities in two of the shard bathrooms was required to ensure the safety of all residents using the facilities and to reduce the risk of the spread of health-associated infectious deceases.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspector found that overall, there were appropriate systems in place for the prevention and detection of fire.

However, to ensure that adequate provision was made for all residents' safe evacuation from the centre, improvements were needed to ensure that the two fire exit doors in the house and the fire escape meeting point, were clearly identified as such.

In addition, improvements were needed to the fire alarm panel system to ensure, that in the case of a fire, staff were able to identify where the fire might be.

The health and safety audit completed in April 2022, had identified that staff required training on the fire alarm system and that a mechanical arm was required for the kitchen door, the latter being noted as urgent. However, on the day of the inspection neither actions had been completed and there was no plan or time-line in place for them to be completed.

Judgment: Substantially compliant

Regulation 8: Protection

On speaking with residents and staff, and on review of associated documentation such as daily logs, personal plans, risk assessments and incident reports, the inspector found that ongoing behavioural incidents occurring in the centre, were having a negative impact on residents' lives. Due to compatibility issues, not all residents felt safe in their home and at times, were afraid and anxious in their home

and in the community. Not all residents were comfortable about making complaints about the situation in case it lead to further incidents.

The national safeguarding team and HIQA and been notified regarding three safeguarding incidents that occurred in the designated centre in 2021, one which related to the compatibility issues in the house. A safeguarding plan had been put in place and one of the measures to reduce the risk of safeguarding incidents recurring included, staff monitoring residents when they were together in a communal space in the house. A review of the plan was to take place monthly, however, the plan had not been reviewed since August 2021.

The safeguarding plans were not always easily available to staff. For example, where appropriate, not all safeguarding plans were included in residents' personal plans and on the day of the inspection, the staff team had no easy access to the plan.

Not all safeguarding incidents had been reported in line with the national safeguarding policy and procedures. Two examples, (in November 2021 and June 2022), where on-going behavioural incidents impacted negatively on residents safety and wellbeing had not been reported in line with best practice.

On review of a sample of adverse incidents, the inspector found that improvements were needed to the recording of local incident reports to ensure they clearly relayed the impact behavioural incidents had on all residents who were involved in, or witness to, the incident.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ard na Greine OSV-0001689

Inspection ID: MON-0033714

Date of inspection: 23/06/2022

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • PIC has now delegated some admin to delegated staff in both Centre's, this will enable the PIC to have more oversight of governance and management 10th July 2022. • A Deputy CSM will be in place by 31st October 2022.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Currently advertising for the recruitment of social care workers to fill this vacancy. Person in charge will endeavor to have the same agency staff to ensure continuity until this role is filled.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training schedule in place and reviewed by PIC regularly. • All staff will have completed risk and incident management training by 30th Nov 2022.	

• Fire alarm panel training for staff will be completed by

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Separate Annual review for Ard Na Greine to be completed by Oct 2022.

• PPIM has joint access to information, governance and management and supervision. All information and procedures relating to the welfare of the residents are now located in a locked filing cabinet which has been clearly labeled and all staff are aware of the location of the key. The contents of this filing cabinet will be explained to all staff at the next staff meeting on 20th July 2022. This information is also located on CID, further CID training for staff to be scheduled to be completed by 31 Oct 2022.

• Should there be an application via the referrals committee all policies and procedures will be followed, this will include risk and compatibility assessments.

• PIC had a discussion with resident in line with their will and preference on how to make more use of their sitting room to include having refreshment and activities with their friends during agreed scheduled times taking into account other residents in the house 1st July 2022. This was discussed at the residents' meeting and all residents agreed to the plan, scheduled on 26th July 2022.

• PIC had discussion with two other residents about their health and wellbeing in line with their will and preference (June 2022). One resident has expressed a preference to have motivational sessions, and these will commence 30th September 2022. PIC will have monthly discussions with SHS Behavioral Specialists, and meetings with SHS Social Worker. Counselling to continue for one resident and to commence with second resident.

• Behavior Support Specialist has visited the designated Centre and engaged with the resident in relation to their PBSP on the 12th of July 2022. The BPSP will be reviewed by 30th September 2022 and any changes to the behavioral support plan to be discussed with and agreed with resident Sept 2022.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• Review of Tenancy agreement and Contract of Care for all residents.
• Several key working sessions to ensure the residents have a good understanding of both forms by 31st October 2022.
• The Admissions policy will be reviewed by 19th August 2022 and submitted to HIQA
• All future admissions to the Centre will include a compatibility and risk assessment

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Going forward all NFO6 will be submitted to HIQA, A number of safeguarding notifications have been submitted retrospectively.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Review of all risk assessments and risk register for the designated Centre will be undertaken and in line with company policy by 30th September 2022. PIC will continue to review risk register on a monthly basis.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
All linen towels have been removed and paper towels have been put in place in shared bathrooms. Pedal bin was put in place on the 28th of June 2022.

All resident's isolation plans will be reviewed and updated by 31st August 2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• One front door to be modified to ensure that it is clear it is not an emergency exit door by 30th September 2022.
• Assembly point for evacuation is across from the front of the house. This will be included in the safety plan and all staff and residents will be informed of this during staff and residents' meetings and emergency evacuations drills.
• Fire alarm training to be completed in end of August 2022
• Mechanical arm to be fixed on door by the 9th of September 2022
Evacuation and safety plan will be displayed in Centre by end Oct 2022

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
New safeguarding plan was created on 1st July 2022 in collaboration with CHO6 social worker. This has been sent to and approved by CHO6 safeguarding team on 13th July 2022. The plan has been discussed and shared with all staff team and has been discussed and agreed with the resident on 21st July 2022.
Safeguarding plan for 2nd resident will be completed by 28th July 2022 and forwarded to CHO6 Social Work department.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	31/10/2022
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	30/10/2022
Regulation 15(3)	The registered	Substantially	Yellow	30/10/2022

	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.	Compliant		
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/11/2022
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.	Substantially Compliant	Yellow	31/10/2022
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'	Not Compliant	Orange	31/10/2022

	needs, consistent and effectively monitored.			
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Substantially Compliant	Yellow	31/10/2022
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2022
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Orange	31/10/2022
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	30/11/2022
Regulation 26(2)	The registered	Substantially	Yellow	30/09/2022

	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 responding to emergencies.	Compliant		
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.	Substantially Compliant	Yellow	31/08/2022
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/09/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2022
Regulation 28(4)(a)	The registered provider shall	Substantially Compliant	Yellow	30/09/2022

	make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/08/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/07/2022
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is	Substantially Compliant	Yellow	31/07/2022

	harmed or suffers abuse.			