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:	Parknasilla
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	24 November 2022
Centre ID:	OSV-0001691
Fieldwork ID:	MON-0037375

About the designated centre

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

Parknasilla is a designated centre operated by Sunbeam House Services Company Limited by Guarantee. Parknasilla offers residential services for up to ten adults with disabilities (both male and female). It is located in Co. Wicklow within walking distance of a large town which provides access to a range of community based amenities to include hotels, restaurants, pubs, parks, shops and shopping centres. The centre comprises of two large houses on the same street and one small bungalow (Lodge) approximately a kilometer away. Each resident has their own individual bedroom, decorated to their individual style and preference. Communal facilities are provided including kitchen/dining room, sitting rooms, visitors' room and a TV room. The centre is staffed with an experienced and qualified person in charge. The person in charge is supported in their role by a deputy manager and a team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 24 November 2022	10:15hrs to 18:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This was an unannounced inspection. On arrival at one of the three houses that make up the designated centre, the inspector briefly met with the deputy manager who was finishing up a work shift. Shortly afterwards the person in charge arrived at the centre and met with the inspector. Residents were informed about the inspection and asked if they wanted to meet the inspector.

On the day of the inspection, the inspector met with all four residents living in one house. Most of the residents in the second house were out when the inspector called however, the inspector got the opportunity to meet with one of the residents for a brief chat. The inspector did not visit the third house as there was no residents living in it at the time. In the first house, some of the residents spoke briefly with the inspector while other residents chose to having a meeting with the inspector to relay their views about living in their home. One residents showed the inspector around some of the rooms in the house, including their bedroom. The resident appeared happy to show the inspector their room and the inspector observed that the layout and design of the resident's room was decorated to their personal taste and wishes.

One of the residents, who met with the inspector on their own, informed the inspector that they were not happy with who they were living with. The resident said that there was a lot of shouting in the house and sometimes they were kept awake. The resident told the inspector that they had made a number of complaints but that nothing ever happened. They expressed their frustration at not been kept informed of some of the plans for the centre. For example, they were advised that one of their fellow residents were moving to a new location in October and when they questioned why it had not happened, they were informed they were moving in November. It was evident that the resident was very upset about this matter and was keen to get a response that would inform them of the plan in place.

Another resident met with the inspector in the company of the person in charge. They told the inspector that overall they were happy in their home and of the support they received from staff however, they wanted to move out of the house to live with the person they were in a relationship with. Earlier in the day, the inspector had been informed by the person in charge, that the resident was been supported to attend a relationship course to provide support and education around this goal. The resident talked to the inspector about some of the worries they had coming close to the Christmas period. The resident informed the inspector that they could talk to their keyworker or the person in charge about these worries when they needed to.

During the day the inspector observed the residents coming and going to different activities in the community. Some residents stayed in their home for the day. During this time the inspector observed them to watch television, bake a home-made tart

and and listen to relaxation music.

The inspector observed that the residents seemed happy in the company of staff and that staff were respectful towards the residents through positive, caring and jovial interactions. During brief conversations with staff through-out the inspection, the inspector found that staff were knowledgeable of the needs of residents and the supports required to meet those needs.

The inspector had been made aware that a resident had recently passed away in the centre. Overall, the inspector found that the person in charge and staff had been thoughtful, caring and compassionate when supporting the resident during the final weeks of their life. The family of the resident had thanked the staff for the care and support they provided to their family member during this time. The person in charge informed the inspector that staff were supporting residents with their grief and that organisationally there were further supports being put in place for both staff and residents. On speaking with staff, the inspector was informed that while they were supporting residents with the loss, they too were dealing with the loss and that resident was missed by everyone.

The inspector observed, for the most part, the two houses to have a homely feel. Overall, the houses appeared clean and tidy and there had been some improvements to the cleanliness of the houses since the last inspection. However, the inspector observed that much of the upkeep and repair work that had been identified on the last inspection, was still in place and overall, had deteriorated further. As such not all areas of the designated centre were conducive to a safe and hygienic environment. In addition, the external areas of two of the houses appeared unkempt. Outside the back of one house and to the front of another house, the inspector observed a number of rubbish bins to be overflowing. Furthermore, there was an old badly stained mattress placed at the back of one of the houses, which was also obstructing a fire escape route. On the day of the inspection, the person in charge organised that the bins were tidied and on the following day, that the mattress was taken away.

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 staff and the local management team were endeavouring to ensure that residents were in receipt of good quality care and support. While there had been a number of improvements implemented since the last inspection, which resulted in staff being more available to the residents living in the centre, further improvements were needed to ensure a positive lived experience for all residents living in the centre.

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

This risk based inspection was carried out to follow-up and monitor compliance regarding a previous inspection of the centre in May 2022 where the provider had not complied with a number of regulations relating to protection, staffing, governance and management, infection control and fire precautions. Subsequent to the inspection, the provider was required to attend a warning meeting with HIQA and was issued with a warning letter outlining the potential further enforcement or escalation actions that may be taken by the Office of the Chief Inspector should the provider not bring the centre back into compliance.

The provider had submitted a satisfactory compliance plan however, subsequent to submitting the plan, the provider contacted HIQA to advise that not all actions on the plan could be completed within the stated timeframe; There had been a further delay with the plans to support a resident move to a home that better met their needs. The expected availability of the location had changed. As such, while the provider was continuing to work on making the location available, the timeframe of the transition of the resident to this location was unknown. The provider had advised that in the interim, additional staffing hours would be put in place to further support the resident participated in activities of their choice in the community and also in an effort to reduce the compatibility issues within the house. However, on the day of the inspection, the interim arrangements had not been satisfactory implemented.

The provider had however, made a number of improvements since the last inspection. Overall, the staffing arrangements to support residents living in the centre had improved. In addition, the provider had filled a number of vacancies including a new person in charge and a new deputy manager. The provider had also completed the maintenance work relating to an application to vary a condition of their registration, which had been submitted in relation to the change of layout of two rooms in an effort to better support compatibility issues in the house.

However, the inspector found, that not all actions had been fully implemented or in some cases, completed. In addition, some of the governance and management systems, that endeavoured to ensure the service provided was safe, appropriate to the residents' needs and effectively monitored, were not effective at all times.

There were improvements to the local governance and management arrangements for the designated centre. A new person in charge had commenced in their role in early September 2022. The inspector found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives. A new deputy manager was also employed and were part of the support team for the person in charge. The inspector found that there had been also a number of improvements to both the staffing levels and staffing arrangements in the centre which had resulted in positive outcomes for residents.

Overall, the registered provider was endeavouring to ensure that the number, qualification and skill-mix of staff was appropriate to the number assessed needs of

the residents, the statement of purpose and the size and layout of the designated centre.

Since the last inspection the provider had employed an additional four staff members. Furthermore, staff were no longer required to support individuals who were not residents of the designated centre, as was found on the last inspection and impacting on the quality of support to residents, which resulted in staff having more time to provide care and support to the residents living in the centre.

However, at the time of the inspection, there remained two staff vacancies. One of the vacancies was specifically related to an interim strategy to reduce the risk of behavioural incidents occurring in the house.

Agency staff were employed to cover vacancies as well as covering staff leave. While the person in charge was endeavouring to employ the same cohort of agency staff, continuity of care could not always be ensured.

Since the last inspection, there had been improvements to the training provided to staff. Staff had been provided with additional training that better met the needs of the residents. There was a training schedule in place however, on review of the schedule the inspector saw that a number of staff training was out of date, including some refresher training.

Regulation 14: Persons in charge

The inspector found that the person in charge had a clear understanding and vision of the service to be provided. Staff spoke positively about some of the changes the person in charge had implemented since they commenced in the role.

On observing interactions between the person and charge and residents, the inspector found them to be caring, mindful and respectful in these interactions and it was clear that the person in charge was aware of the needs of the residents and of the support required to meet them. Since commencing their role, the person in charge had regularly met with residents, on a one to one basis, to discuss issues and matters that were important to them.

Judgment: Compliant

Regulation 15: Staffing

The provider had carried out a number of staff recruitment days in an effort to increase resources in both the centre and organisationally.

Since the last inspection,there had been improvements to the staffing arrangements

in the centre; Staff were no longer supporting individuals who were not part of the designated centre and had more availability to support the residents living in the house. For example, staff had more time to support residents attend appointments, community activities and for one to one engagements.

The provider had employed three additional staff since May 2022 and since September 2022, had employed a further staff member and a new person in charge. However, two vacancies remained outstanding (120 hour and 56 hour roles).

The provider had sourced funding for the additional 56 hours per week to recruit a staff member to support a resident on an one to one basis to have further involvement in their community through activities of their choice. This was also an interim measure, to reduce the risk of potential behavioural and safeguarding incidents occurring between residents in the house. However, on the day of the inspection, the vacancy had not been filled.

Agency staff were employed to work in the centre. The person in charge was endeavouring to employ the same agency staff as much as possible. On review of the staff roster, there were some weeks where one agency staff member was required and others where there was two to three agency required. This was to cover the vacancies but also to cover staff leave. Overall, there had been a reduction in use of agency staff since the last inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had been provided with training to meet the assessed needs of all residents. Since the last inspection, most of the staff team had completed training related to Dementia care.

Overall, on review of the training schedule in place, the inspector saw that staff were provided with an array of training including training on safeguarding vulnerable adults, managing behaviours that challenge and de-escalating techniques, infection prevention and control, first aid and safe medical management but to mention a few. However, a number of staff training, including refresher training was out of date. For example, three staff were due dementia care training, two staff due fire safety training, two staff were due safe medical management refresher training, and four staff were due safeguarding vulnerable adults training.

Staff were in receipt of one to one supervision meetings to better support them in their role. The person in charge was in the process of scheduling supervision meetings with staff for the remainder of the year and into 2023.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the provider had made improvements since the last inspection, further action was required to ensure that outstanding actions were implemented and that systems in place that ensured the safety of residents were effective at all times.

The systems in place to ensure the quality and safety of care and support in the designated centre were not adequate at all times both at provider level and at local level. While an unannounced six monthly review of the centre had been carried out in September 2022, on the day of the inspection, there was no action plan or timeline in place for the person in charge to follow up on. Local household audits, that were part of the monitoring system to evaluate and improve the provision of care provided in the centre, had been completed for September 2022 however, had not been completed for July, August or October 2022.

The provider had not ensured that the fire safety management systems in place in the centre were effective at all times. While the provider had identified some of the risks relating to fire precautions in the centre, there was no definitive plan ,or timeline, in place to address them.

In addition, while the provider was endeavouring to reduce compatibility issues in the house, further oversight of recorded safeguarding incidents was needed to ensure that they were appropriately followed up on and notified to HIQA when required. In addition, improvements to information governance arrangements regarding notification requirements was needed overall.

The provider was endeavouring to progress the plans to relocate a resident to another house in the centre. Subsequent to the inspection the inspector was advised that other alternative would be sought if the current plan did not fall into place. The provider had put an interim arrangement, of additional resources, to better support the assessed needs of a resident while they were waiting to locate to home that better met their needs, however, these had not been adequately put in place. As such, the potential risk of further safeguarding incidents occuring in the house continued.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector found that improvements were required to ensure that there was effective 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.

On reviewing a sample of incident logs, the inspector found that not all safeguarding incidents had been notified to HIQA.

In addition, on review of two occasions where residents required hospital treatment, they either were notified through the incorrect notification or not notified at all.

Judgment: Not compliant

Quality and safety

Since the last inspection, there had been a number of improvements to the governance and management arrangements in place which, positively impacted on the quality and safety of care and support provided to residents living in the centre. However, due to the centre not meeting the needs of all residents, there was a continued risk of safeguarding incidents occurring in the residents' home. This situation was likely to remain until interim staffing strategies were fully implemented. There were also improvements needed to the centre's fire safety management systems so that residents safety was ensured at all times.

Since the last inspection in May 2022 there had been a reduction in the number of safeguarding incidents notified to HIQA. The provider had made a number of improvements to support the reduction of safeguarding incidents occurring in the centre. Staffing arrangements had been changed so that staff were more available to better support the residents living in the designated centre. The person in charge regularly carried out one-to-one meetings with residents to discuss any upset or issues that they had with their fellow residents and had also set up a relationship building support for some residents. The layout of one house had been changed in an effort reduce noise levels so that residents could sleep better and overall, reduce the number of incidents occurring in the house.

However, despite the reduction, there continued to be compatibility issues in both houses that made up the designated centre. In addition, the centre was not meeting the needs of all residents, which at times, resulted in behavioural incidents which impacted negatively on residents lived experience in their home.

The person in charge and staff were endeavouring to implement, where appropriate, residents' behavioural support plans in an effort to lessen the impact on residents and overall, support the reduction in behavioural incidents occurring. Overall, the change in staffing arrangements had supported a reduction in incidents as it better ensured appropriate staffing levels when implementing strategies including in residents' behavioural support plans.

For the most part, the person in charge had initiated and put in place investigations in relation to incidents, allegations or suspicion of abuse and took appropriate action

if a resident was at risk of abuse. However, on review of the centre's incident log, the inspector found that not all potential safeguarding incidents, had been notified as required. In addition, a recent notification required review and updating, to ensure it accurately relayed the residents who were impacted by the incident.

Where appropriate, residents were provided with safeguarding plans however, most of these plans were interim plans and had not been reviewed since February 2022 and were not included in residents' personal plans. The provider had identified in October 2022 that residents' safeguarding plans required updating however, as of the day of inspection, the updating of the plans remained outstanding.

The provider had submitted a notification to HIQA of the death of a resident as required by the regulations. The provider had put in place a number of policies and procedures to guide staff in delivering safe and appropriate care for residents at the end of their life. Overall, the guidance within the policies and procedure were followed and the appropriate services, including palliative care support, was made available to the resident.

The inspector observed the designated centre to be clean and tidy. However, not all areas were conducive to a safe and hygienic environment. This was primarily due to the required upkeep and repair to a number of areas of the centre, including fixtures and fittings within each of the premises.

Notwithstanding the above, there had been improvements in the cleanliness and overall, tidiness of the centre. The person in charge had developed and implemented new and improved cleaning schedules and checklists. On review of the checklist and general observations of the houses in the centre, it was evident that staff were adhering to the schedule.

The fire safety management systems in the centre required improvements to ensure they were effective at all times. Since the last inspection, there had been upkeep and repair to a number of fire doors so that they were effective at all times. However, the provider had not ensured that all compliance plan actions relating to fire doors had been completed. In addition, some of the issues that had been previously identified, such as fire doors wedged open and evacuation routes obstructed, were observed to be in place again.

The provider had identified the issue regarding the doors being wedged opened in September 2022, through their provider-led unannounced six monthly audit of the quality and care of support in the centre, however, there was no action plan or timeline to address this issue. Furthermore, the inspector observed damage to one of the house's hall ceilings, which due to its proximity to electrical and sensory systems, potentially impacted on the safety of residents living in the house.

Regulation 27: Protection against infection

While the person in charge had implemented a number of strategies to improvement

infection prevention and control measures in the house overall, further improvements were needed to ensure that all areas of the centre were conducive to a safe and hygienic environment.

A number of the centre's door-frames, window-frames, walls, radiators and banisters, presented with chipped and peeling paint which meant that they could not be cleaned effectively and potentially increased the risk of spread of healthcare-associated infections in the centre. These had been identified on the previous inspection and the provider had committed, through their compliance plan to complete the maintenance work by June 2023, however, it was observed by the inspector that the state of disrepair of these areas had further declined and a review of the completion date for the maintenance work was needed.

Outside the back of one house and to the front of another house, there were a number of rubbish bins observed to be overflowing. There was also a badly stained mattress placed at the back of one of the houses. However, on the day of the inspection, the person in charge organised that the bins were tidied and on the following day, that the mattress was taken away.

Judgment: Substantially compliant

Regulation 28: Fire precautions

During a walk around of the two house in the centre, the inspector observed three doors wedged open. The inspector was informed that these doors were usually kept open for supervision purposes and in line with residents' likes and preferences. The provider's health and safety audit had actioned mechanical door opening arms, (that linked to the alarm system), to be fitted however, this action had not yet been completed.

Since the last inspection, one of the house's fire alarm panel was provided with a legend to identify, in the case of a fire where it was located. However, there was no legend provided on the fire alarm panel of the other house.

The inspector observed an old mattress partially obstructing one of the fire escape routes. While the person in charge had raised this issue with the maintenance department previous to the inspection, as on the morning of the inspection, there was not date provided for its removal. However, by the evening of the inspection, a date for its removal had been provided and the day after the inspection, the person in charge submitted evidence to demonstrate the mattress had been removed.

The disrepair to the upstairs hall ceiling in one of the houses, was due to a leak. As a result, there was a hole and a crack in the ceiling. The ceiling was also dipping around this area. There was six sockets, a fire sensor alarm and a fire emergency light in close proximity to the area of the disrepair. The person in charge advised that the damaged had been viewed by the maintenance department however, on

the day of the inspection, there was no action or timeline to fix it.

Overall, the untimeliness of addressing the above tasks impacted on the safety of all residents living in the centre.

Judgment: Not compliant

Regulation 6: Health care

On speaking with the person in charge and staff and on review of documentation in place, the inspector found that a resident who had recently passed away in the centre, was provided with a good standard of end of life care. Staff had endeavoured to ensure that the resident experienced comfort, compassion and dignity during the final stages of their life. On speaking with the person in charge, the inspector was informed that the resident's family expressed thanks to the team regarding the good quality of care and support they provided to their family member, and to them, during this time.

Overall, on review of the documentation and speaking with the person in charge and staff, the inspector found that the the centre's policies and procedures had been followed when supporting the resident and appropriate end of life care was provided to the resident.

However, the inspector found that some improvements to the current practice in place was needed. This was to ensure that residents' wishes and preferences, regarding all aspects of their end of life care and support, were discussed in advance of requiring this type of care and support and included in their personal plans .

Judgment: Substantially compliant

Regulation 8: Protection

The provider had made a number of improvements to support the reduction of safeguarding incidents occurring in the centre. However, through speaking to residents and on review of a sample of incidents, the inspector found that compatibility issues remained ongoing and at times, resulted in behavioural and safeguarding incidents.

Overall, improvements were needed to ensure that systems in place, that ensured the safety of residents, were effective at all times and adequately supported the reduction incidents recurring. Below are some of the issues identified on the day of the inspection;

Not all safeguarding plans were appropriately updated or included in residents' personal plans. Not all incidents, that negatively impacted on residents, were appropriately followed up in line with national safeguarding policy and procedures or were notified to HIQA. Plans to support a resident relocate to a residence, that better met their needs, had not yet been implemented. Interim staffing arrangements, to better support the resident further engage in community activities and potentially reduce the risk of safeguarding incidents, had not been adequately put in place.
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	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Parknasilla OSV-0001691

Inspection ID: MON-0037375

Date of inspection: 24/11/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: PIC in collaboration with HR department will continue to prioritise filling 56 hour vacancy. PIC will continue to endeavor to have a skilled mix of staff rostered each shift and where possible to roster familiar staff with agency if agency is required. PIC liaises with agencies to ensure the locations are staffed with familiar agency staff which improves consistency across locations in so far as is reasonably possible. Every effort is being made by the provider to recruit staff to provide consistency and continuity of care to support the respite users The Provider implemented the below strategies in relation to the recruitment of staff. • The Provider ran an open day on the 8th of November 2022. SHS will be planning another such event in the New Year . • SHS ran recruitment advertisements on local radio and multimedia formats in November 2022. • SHS are exploring running 2 Open Days overseas in 2023. • The Human Resource department will be attending some college Open Days in 2023 when college schedules are confirmed.	
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
PIC to continue to complete supervision with all staff.

Training outstanding on day of inspection:
Fire Training: all outstanding training completed.
Dementia Training to be scheduled in early 2023. PIC in contact with training department to schedule as soon as is available.
Medication refresher: all outstanding training is completed.
Safeguarding vulnerable adults: all outstanding training is completed.

PIC has reviewed training matrix and liaised with staff with any outstanding training.
PIC has liaised with Sunbeam training department and booked training for staff team for 2023 to ensure staff training is completed before expiry dates.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PIC responding to action plan for September unannounced 6 monthly provider audit. The actions were attached to the 6 monthly audit but unfortunately were overlooked.
Plan to be responded to by 16.12.22.
All household audits now up to date and uploaded to SharePoint system.
PIC has created an internal audit folder to ensure all location audits are completed and filed in a timely manner. PIC has support from DCSM and staff team for completing audits.

The providers electrician is due inspect the designated centre in relation to assessing works required for door closures on fire doors in January 2023. The work will be completed in mid February 2023. The legend on the fire alarm panel will be addressed by end of January 2023. A fire safety company has assessed all emergency lighting and fire sensors on the 12.12.22 and all is in good working order.

The leak in the designated centre was reparied on 2.12.22
The crack in the ceiling this will be assessed and a quote obtained by end of February 2023.

The PPIM contacted housing and facilities department on 21.12.22 to discuss timeframe

to address painting these areas, whilst the contractors have confirmed this date, should an earlier date become available to address the above the housing and facilities department have agreed to prioritise these works.

Housing meeting scheduled took place on 14.12.22 to discuss client moving to their new location and the barrier of another non designated center client residing in this location. Again various options were explored without success
Should an alternative location become available this will be conveyed to that client and the move for the designated center resident will again be revisited.

The PPIM will resubmit a business case to the HSE to include a request of an alternative sole occupancy dwelling for the designated centre resident by 28.2.22 following costings and exploration of options in line with the client's will and preference.

An update in relation to additional resources, to better support the assessed needs of a resident and reduce safeguarding was provided to HIQA on 30.11.22
Support plan was completed for one resident on 02.12.22. This plan has been constructed to provide this resident with more 1:1 day support and reallocated some resources to do so within the cluster. This aims to provide a greater variety of activities with a focus on the afternoon/evening when negative interactions are more likely to occur. The overall aim is to provide this resident with further stimulation and to build on positive relationships with other residents.

Update 18/01/202
The fire legend will be displayed above the fire panel on 25/01/2023

A device will be installed to keep fire doors in the open position / and will activate to the closed position when fire alarm is activated on 25/01/2023

To further clarify the additional resource used to support one specific resident in the designated center has the following in place:
1 to 1 staffing available to this resident for any activity engagement. Should the resident wish to have time alone staff will be sensitive and responsive to same, however will still be available as and when the resident wishes.

An activity choice board is being constructed by the PIC / staff on site and will be implemented by 1/02/2023. This will allow a new approach to offer the resident preferred activity choices throughout the day and evening in line with the resident's will and preference.

There are systems in place during handover in the designated center in the morning whereby a staff member is allocated to support this resident on a one to one basis.

The PIC will incorporate all of the above measures into an individualized care plan for this resident and this will be completed 20/01/2023 and communicated to the staff team.

A business case was submitted to the HSE on 01/06/2022 and resent on 29/09/2022, a further business case will be submitted to the HSE by 03/02/2023 to include a request for further resources to meet the resident's needs to facilitate the resident moving to a single occupancy dwelling.

An emergency internal referrals meeting was held on 19/01/2023 to discuss possible options for this resident to discuss transitioning to an alternative designated center.

Two clients have expressed a wish to move to a designated center due to changing needs, this is now at the compatibility assessment stage. If successful, this could create capacity for the resident to be placed in a sole occupancy apartment (with sleepover support from staff)

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PIC has reviewed systems in place to notify HIQA of any incidents and has submitted outstanding notifications.
PIC continues to review all issues of concern and follows procedure where safeguarding concerns are raised.
PIC has resubmitted previous concerns to safeguarding upon further review.
PIC liaises with Sunbeam social work and HSE to follow up and complete same.
PIC has created individual safeguarding plans for clients across both locations.
All hospital notifications updated on HIQA portal.
All HIQA Portal notifications / relevant safeguarding actions in conjunction with CHO Safeguarding team have been completed in November apart from the relevant quarterly notification which will be completed in January 2023. HIQA were notified of this action on 30.11.22.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Regular Housekeeping audits are completed in both locations, to ensure items such as noted on the day of inspection "over-flowing bins" do not reoccur.

New household cleaning folders to continue across both locations and any issues

reported to PIC. PIC to check cleaning schedules are being completed. All schedules uploaded onto internal database each week. This has been very successful to date.

The leak in the designated centre has been reparied on 2.12.22
The crack in the ceiling this will be assessed and a quote obtained by end of February 2022.
A fire safety company has assessed all emergency lighting and fire sensors on the 12.12.22 and all is in good working order.

The PPIM contacted housing and facilities department on 21.12.22 to discuss timeframe to address painting these areas, whilst the contractors have confirmed June 2023, should an earlier date become available to address the above the housing and facilities department have agreed to prioritise these works.

Update 18/01/2023
A number of contractors have been engaged to complete these works, and it is anticipated that the works will be completed before 01/05/2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC will ensure that the staff team are consistently reminded of their fire safety checks which include ensuring there are no obstructions along evacuation routes and this will be discussed at the next staff meeting scheduled in January 2023.

The providers electrician is due inspect the designated centre in relation to assessing works required for door closures on fire doors in January 2023. The work will be completed in mid February 2023. The legend on the fire alarm panel will be addressed by end of January 2023. A fire safety company has assessed all emergency lighting and fire sensors on the 12.12.22 and all is in good working order.

Update 18/01/202
The fire legend will be displayed above the fire panel on 25/01/2023

A device will be installed to keep fire doors in the open position / and will activate to the closed position when fire alarm is activated on 25/01/2023

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: End of life plans for the residents in the designed will to be discussed between the PIC and PPIM by end of February 2023, following this according to the residents will and preferences plans will be created that ensure that residents' wishes and preferences, regarding all aspects of their end of life care and support, are discussed in advance of requiring this type of care and support and included in their personal plans, Update 18/01/2023 Due to recent bereavement of a resident in the designed center (of which residents in both houses intermingled and had long standing relationships with the co-resident, a sensitive and individualized approach for each resident will be taken to complete end of life planning. 18/01/2023 the PIC has made an internal social work referral to begin the process of end-of-life planning for each resident. The timeframe for completion of this action will depend on each residents' emotional needs.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Individualised safeguarding plans created for all residents across both locations, this has been completed by the PIC. Housing meeting scheduled took place on 14.12.22 to discuss client moving to their new location and the barrier of another non designated centre client residing in this location. Viable options were explored again without success Should an alternative location become available this will put conveyed to the resident and the move for the designated center client will again be revisited. The PPIM will re-submit a business case to the HSE to include a request of an alternative sole occupancy dwelling for the designated centre resident by 28.2.22 following costings and exploration of options in line with the client's will and preference. An update in relation to additional resources, to better support the assessed needs of a resident and reduce safeguarding was provided to HIQA on 30.11.22 Support plan was completed for one resident on 02.12.22. this plan has been constructed to provide this resident with more 1:1 day support and reallocated some resources to do so within the cluster. This aims to provide a greater variety of activities with a focus on the afternoon/evening when negative interactions are more likely to occur. The overall aim is to provide this resident with further stimulation and to build on positive relationships with other residents.	

The Provider implemented the below strategies in relation to the recruitment of staff.
• Regarding recruitment, the Provider ran an open day on the 8th of November 2022. SHS will be planning another such event in the New Year .

• SHS ran recruitment advertisements on local radio and multimedia formats in November 2022.

• SHS are exploring running 2 Open Days overseas in 2023.

• The human resource department will be attending some college Open Days in 2023 when college schedules are confirmed.

All notifications reviewed and resubmitted where applicable. Issues of concern reviewed, and safeguarding submitted to CH06 where applicable. PIC taking extra care when reviewing and submitting issues of concern and notifications going forward.

Update 19.1.23
To further clarify the additional resource used to support one specific resident in the designated center has the following in place:
1 to 1 staffing available to this resident for any activity engagement. Should the resident wish to have time alone staff will be sensitive and responsive to same, however will still be available as and when the resident wishes.

An activity choice board is being constructed by the PIC / staff on site and will be implemented by 1/02/2023. This will allow a new approach to offer the resident preferred activity choices throughout the day and evening in line with the resident's will and preference.

There are systems in place during handover in the designated center in the morning whereby a staff member is allocated to support this resident on a one to one basis.

The PIC will incorporate all of the above measures into an individualized care plan for this resident and this will be completed 20/01/2023 and communicated to the staff team.

A business case was submitted to the HSE on 01/06/2022 and resent on 29/09/2022, a further business case will be submitted to the HSE by 03/02/2023 to include a request for further resources to meet the resident's needs to facilitate the resident moving to a single occupancy dwelling.

An emergency internal referrals meeting was held on 19/01/2023 to discuss possible options for this resident to discuss transitioning to an alternative designated center.

Two clients have expressed a wish to move to a designated center due to changing needs, this is now at the compatibility assessment stage. If successful, this could create capacity for the resident to be placed in a sole occupancy apartment (with sleepover support from staff)

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	30/06/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	31/12/2023

	training, including refresher training, as part of a continuous professional development programme.			
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.	Substantially Compliant	Yellow	30/06/2023
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.	Substantially Compliant	Yellow	01/06/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on	Substantially Compliant	Yellow	31/03/2023

	the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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	30/06/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	28/02/2023
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/12/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and	Not Compliant	Orange	31/12/2022

	extinguishing fires.			
Regulation 31(1)(d)	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 serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	31/01/2023
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	31/01/2023
Regulation 06(3)	The person in charge shall ensure that residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.	Substantially Compliant	Yellow	31/01/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of	Not Compliant	Orange	01/04/2023

	abuse.			
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 harmed or suffers abuse.	Substantially Compliant	Yellow	01/12/2022