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:	Collins Avenue
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	27 January 2022
Centre ID:	OSV-0005059
Fieldwork ID:	MON-0031443

About the designated centre

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

Collins Avenue is a designated centre operated by St Michael's House located in a suburban area of north County Dublin. The centre provides a community residential services to two adults (male and female) with a disability. The house is divided into two individualised areas separated by a door at the bottom of the stairs. The residents have individualised areas of the centre with access to a shared entrance, kitchen and dining area, store room and utility room. The upstairs of the centre contained a bedroom, sitting room, bathroom and two staff rooms for the sleepover staff. The downstairs contained a bedroom, bathroom, living room and the shared entrance, kitchen and dining area, store room, and utility room. The centre was staffed by a social care leader, social care workers and care workers. Residents had access to nursing support through a nurse on call service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 27 January 2022	09:15hrs to 18:00hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

On the day of inspection, there were two residents living in the designated centre. The inspector was advised by the person in charge that the inspector's presence in the centre could cause disruption for the residents. Based on this information, the inspector spent the morning in the centre, and the afternoon in one of the provider's administration offices. The inspector briefly met one of the residents before both residents left the centre to partake in separate activities. The resident did not verbally communicate their views of the service to the inspector. There were three staff members on duty, two were assigned to support one resident, and one was assigned to support another resident. The inspector observed staff members to engage with the residents in a respectful and familiar manner. Staff members were observed to wear appropriate personal protective equipment (PPE) in line with public health guidance.

The premise consisted of a large two storey house with front and back gardens. There was one front door entrance; however, the house was 'split' for resident use. One resident had sole use of the ground floor, with the exception of the kitchen, and one resident had sole use of the first floor. Each resident had their own bedroom, bathroom, and living area. There was one shared kitchen which residents had restricted access to, as they could not use it at the same time due to incompatibility issues.

The previous inspection of the centre, in August 2020, found Regulation 17: Premises, not compliant. The registered provider had committed in their compliance plan to resolving the premise issues by 29 April 2023. The inspector completed a walk around of the centre, and found it to require considerable renovation and upgrade throughout. The inspector also found that the infection prevention and control measures, and fire management arrangements in the centre required improvement.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

There were governance and management systems in place to support the delivery of a safe and consistent service that was appropriate to residents' needs. However, improvements were required to ensure that these systems were effective and provided sufficient oversight of the centre.

The previous inspection of the centre, in August 2020, found 'Regulation 17: Premises' and 'Regulation 9: Residents' Rights' not compliant. The registered provider had committed in their compliance plan to resolving these issues by 29 April 2023. The provider has planned to divide the house into two separate dwellings. The provider had engaged an architect, and was pursuing adequate funding for the required renovation and construction work. Until then, there were arrangements for residents to share access to the kitchen and utility room at different times, and kitchen appliances such as a fridge and microwave were available upstairs for the resident residing upstairs to use.

There was a clearly defined management structure. The person in charge was supported in their role by a full time social care leader. The social care leader commenced in post approximately one year ago, and was responsible for the day to day management of the centre. The social care leader reported to the person in charge, who in turn reported to the director of services. The social care leader was on duty during the inspection, however, was supporting a resident on an outing and had limited time to talk with the inspector. The inspector found that the social care leader and person in charge had a good knowledge and understanding of the residents' needs and associated supports. There was regular communication between the person in charge and social care leader. However, the formal communication arrangements required strengthening to demonstrate that the person in charge had sufficient oversight of the centre, for example, there was no formal meetings scheduled for the person in charge and social care leader to discuss the management of the centre.

The provider had implemented mechanisms to review and improve the quality of service in the centre. An annual review was completed for the year 2020; it included consultation with the residents, and their feedback was positive, indicating satisfaction with the service. Six-monthly unannounced audits had also been completed. Areas for improvement were identified in the audits with corresponding actions for completion. Other audits were completed on areas such as health and safety, and medication. To aid senior management in oversight of the centre, the social care leader completed a monthly quality and safety data report. The report was reviewed by the person in charge and director of services, and discussed at relevant management meetings. However, the findings reported under the quality and safety section of this report regarding the premises, restrictive practices, and infection prevention and control measures, did not provide assurances that the centre was consistently monitored.

The were two and half whole time equivalent staff vacancies in the staff complement. The vacancies were impacting on the quality of service. The social care leader was required to work some of the vacant shifts which impeded on their ability to fulfil all of their management duties such as completing formal staff supervision. The vacancies also required the use of relief and agency staff, resulting in residents not receiving continuity of care from a consistent staff team.

Staff received formal supervision from the social care leader. Some of the supervision was overdue; however, it was scheduled to take place in the coming weeks. Informal supervision and support was also provided on a day to day basis.

Staff team meetings were scheduled to take place monthly.

To support staff in the delivery of evidence based care and support, the provider had a comprehensive training programme in place. The inspector reviewed the staff training log with the person in charge, and found that a significant amount of staff training was over due in areas such as fire safety, manual handling, safeguarding residents from abuse, COVID-19, and the safe administration of medication. The delivery of some of this training was delayed due to the constraints of the COVID-19 pandemic. However, some of the training had resumed, and the person in charge was scheduling staff to attend.

The statement of purpose that was available in the centre required review and update as some information was incorrect. The visiting information also required enhancement to reflect that unexpected visitors may cause disruption for residents.

To support in the governance of the centre, the provider had prepared a suite of written policies and procedures. The policies had been reviewed and updated within the past three years and were readily available to staff working in the centre to support them in the delivery of care and support to residents.

There were no open complaints on the day of inspection; however, a complaints log was maintained and there were arrangements in place for the management of complaints. Residents had access to information on complaints and advocacy services, and complaints were regularly discussed at residents meetings.

Regulation 15: Staffing

The social care leader maintained an actual and planned staff rota showing staff on duty during the day and night.

There were two and half whole time equivalent staff vacancies. The provider was actively endeavouring to recruit for the vacancies however, was not successful at the time of the inspection. The use of relief and agency staff to cover the vacancies impacted on the continuity and consistency of care and support for residents. Despite the efforts of the social care leader to only use regular relief staff, the staff rota for January 2022 reflected approximately fourteen shifts covered by agency staff.

The vacancies also impacted on the ability of the social care leader to fulfil all of their management duties as they were required to work some of the vacant shifts.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The social care leader provided informal and formal supervision to staff working in the designated centre. The person in charge was also available to provide support to staff. A schedule of formal supervision was maintained by the social care leader; some of the supervision was over due but had been rescheduled to take place in the coming weeks.

There was a training programme in place for staff; however, the training log records reflected significant areas of outstanding training. For example, of the six staff members represented on the training log:

- Three required training in fire safety
- Three required training in manual handling
- Four required training in the safeguarding of residents from abuse
- Four required training in the management of challenging behaviour
- Five required training in positive behaviour support
- One required training on COVID-19
- Two required training in food safety
- Two required training in the safe administration of management.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the designated centre. The social care leader was based in the centre and was responsible for the day to day management of the centre. The social care leader reported to the person in charge. There was regular communication between the social care leader and person in charge. However, to demonstrate sufficient oversight of the centre, the governance arrangements required strengthening, for example, there were no formal or scheduled meetings between the social care leader and person in charge to discuss the management of the centre. Furthermore, while there were management systems to review the quality of service in the centre such as undertaking annual reviews, six monthly unannounced audits, and monthly quality and safety reports; the findings under regulations 7, 17, and 27, did not provide assurances that that the centre was consistently and effectively monitored.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose. The statement of purpose was available to residents and contained the information set

out in Schedule 1; however, some of the information was not up to date or correct. For example, the registration expiry date, management structure, and person in charge details (on page 3) were incorrect. It also stated that six fire drills including two night time drills take place each year; however, the person in charge informed the inspector that only two fire drills take place each year.

The visiting information also required enhancement to reflect that unexpected visitors may cause disruption for residents.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had provided an effective complaints procedure for residents. The written policy outlined the stages of complaint resolution, and there was a complaints officer with associated responsibilities.

There was information available to residents on the procedure and on advocacy services, and complaints were also discussed at residents meetings to promote understanding of the complaints procedure.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared written policies and procedures on the matters set out in Schedule 5. The policies were readily available to staff. A review of a sample of the policies such as the policies on communication, monitoring and documentation of nutritional intake, behavioural support, intimate care, and safeguarding residents from abuse, found them to have been reviewed and updated as required.

Judgment: Compliant

Quality and safety

The care and support provided to residents in the centre required improvement across several regulations to ensure that it was effective and that it upheld the residents' rights to a quality and safe service.

The provider had implemented measures to protect residents against infection; however, the adequacy of these measures was not sufficient. There was a small storage room containing personal protective equipment (PPE), and information was available on the use of PPE and COVID-19. There was sufficient hand washing facilities in the centre including a clinical sink in the kitchen, and hand sanitiser readily available. The person in charge had completed a risk assessment on COVID-19, and identified associated measures. A monthly infection control audit, as well as a self assessment on COVID-19 precautions had been completed to provide assurances that appropriate measures were in place. There was a daily schedule for cleaning of the centre however, there were gaps the cleaning records during the month of January. As a precaution against COVID-19, residents' temperatures were recorded twice daily; however, there was gaps in these records indicating that the checks did not take place. The 'COVID-19 management plan for positive cases' prepared by the person in charge required enhancement.

As referred to in the first section of the report, Regulation 17, Premises was found to be not compliant during an inspection of the centre in August 2020, the registered provider committed in their compliance plan to resolving the premise issues by 29 April 2023. There were similar findings on this inspection. The premises consisted of a large two-storey house however, the storeys were 'split' for sole resident use. Residents had their own bedrooms, bathrooms, and living space. The bedrooms were spacious and well maintained. There was one kitchen that residents shared, but could not use at the same time due to incompatibility issues. There was clear thick plastic covering the large window on the landing which was institutional in aesthetic.

The premises required considerable renovation, upgrade, and cleaning. Mildew and mould was observed around some of window frames. Both bathrooms required cleaning and renovation. Laminated pictures were observed taped to tiles in a shower and therefor to tiles could not be cleaned properly. The plastic around the pictures was discoloured and presented a hazard of bacteria growth. The kitchen presses were worn and damaged in places, and some of the drawers were dirty. The fridge was clean. There was food debris on the kitchen floor, and the ceiling was stained. The utility room was attached to the kitchen, and contained gym equipment, a washing machine, tumble dryer, and cleaning products. There were thick cobwebs on the walls and ceiling, and the dust pan was ingrained with dirt. In the utility room, clothing and towels were observed on the floor and it was unclear if they were clean or dirty. A clean mop head was also observed on a dirty window sil. The practice of drying clothes on the radiator beside the kitchen table also required review.

The cleanliness issues, poor infection prevention and control practices, and maintenance issues posed a risk to residents and did not promote a safe environment.

There were arrangements in place to prevent and manage an outbreak of fire in the centre, including a comprehensive fire safety management policy with some improvements identified. Fire detection and fighting equipment such as fire extinguishers, alarms, and emergency lights was in place and found to be regularly

serviced. Staff were also completing daily and monthly fire checks; however, the records of the daily checks were incomplete. The inspector inspected the fire doors and found that they closed fully, except for one however, this was resolved by the end of the day. There was no self closing device on the fire door connecting the kitchen and utility room. There was a build up of lint in and around the tumble dryer door this hazard was highlighted to the person in charge. The rear exit door lead from the kitchen to the garden. The door was key operated, but there was a key in the lock and a break glass unit beside it with an additional key.

To guide staff in supporting residents in evacuating during a fire, personal evacuation plans were prepared and were readily available. There were also 'social stories' to support residents in understanding evacuation procedures. Two fire drills took place in 2021 however, the drills not demonstrate that the residents could be safely evacuated with the least amount of rostered staff on duty.

There were arrangements in place for the assessment and management of hazards and risks. There was a written risk management policy, and general and individual risk assessments had been completed. The risk assessments were regularly reviewed to ensure that the associated control measures were effective. The risk related to unexpected visitors in the centre had not been assessed and required consideration. The social care leader was completing monthly health and safety inspections of the centre to ensure that that potential hazards in the centre were managed. There was systems for responding to emergencies such as written local emergency response plans. The plans required review to ensure that they were up-to-date and specific to the centre.

The vehicle used to transport residents was found to be overdue its compulsory national inspection.

Comprehensive assessments of need were completed for residents which informed the development of a suite of personal plans. The plans covered health, personal, and social care needs. A small number of plans and guidelines were overdue review, and some additional plans required development such as mental health and ear care plans.

There were systems in place to support residents with behaviours of concern, and for the governance and management of restrictive practices. However, the systems were not found to be in line with national policy or evidence based practice. Behaviours support plans were completed as required however, one of the plans was overdue review and was not signed by all staff members to indicate that they had read it. To support staff in responding to behaviours of concern, relevant training was available but not all staff had completed the training programmes.

There were several restrictive practices implemented in the centre. The use of some had been approved by the provider's monitoring group however, the approval for others had expired. The decision to implement one particular restriction had been discussed at a management meeting in June 2020. The resident had not been made aware of the practice or given the opportunity to provide informed consent. The rationale for other restrictions was unclear, and it was not clear if informed consent

or approval had been sought. There was a 'house agreement' for the restricted access to the kitchen. This was not signed by the residents or their representatives to indicate that consent had been given. A restrictive practice support plan for one resident was overdue review. The recording of restrictions was found to be inconsistent.

The registered provider had implemented systems to protect residents from all forms of abuse. A sample of records relating to two allegations of abuse were reviewed and indicated that they were managed appropriately and in line with the providers policy on safeguarding residents. Safeguarding plans were developed where deemed required, and there were also specific guidelines to support staff to respond appropriately to safeguarding concerns.

Residents participated in weekly house meetings where topics such as health and safety, rights, and privacy were discussed. Residents also had 'rights' care plans to identify supports they may require in exercising rights. Residents had active social lives and were supported by staff to engage in a variety of activities meaningful to them such as swimming, massage, baking, cinema, shopping, and meeting friends and family. Despite these positive aspects of care and support, the ongoing incompatibility of the residents resulting in restricted access to their home, the poor standard of premise, and the high levels of restrictive practices did not demonstrate that all residents' rights were upheld in the centre.

Regulation 17: Premises

The registered provider had not ensured that the premises of the designated centre was clean and kept in a good state of repair internally:

- The kitchen presses were worn and damaged, and some of the drawers were dirty. There was food debris on the floor, and the ceiling was stained.
- The downstairs sitting room required painting, and cleaning of cobwebs.
- In the upstairs bathroom, the door was chipped, and the base of the toilet and shower tray was unclean.
- In the downstairs bathroom, the ceiling required painting, the wall around the toilet was stained and damaged, and the shower curtain was stained.
- In the utility room, there was thick cobwebs hanging from the ceiling and windows.

There was insufficient kitchen accommodation to allow residents to use the facilities unrestricted.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had prepared a comprehensive risk management policy that underpinned the risk assessment and management arrangements in the centre. The person in charge ensured that risk assessments were completed, and kept under review, for general and individual risks. However, the risk presented by unexpected visitors to the centre had not been assessed.

The registered provider had ensured that there were systems in place to respond to emergencies. Aspects of the systems required improvement; as the local emergency response plans for flooding, loss of water, loss of heating, and gas leak required review and localisation.

The vehicle used to transport resident was serviced regularly but it was over due a compulsory national inspection. The inspection was postponed due to an outbreak of COVID-19 in the centre in December 2021. The provider has rescheduled the inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There was access to appropriate personal protective equipment (PPE), hand hygiene and waste facilities, and relevant infection prevention and control information such as the provider's policies and public health guidance.

The registered provider had not implemented adequate measures to protect residents from the risk of infection. The premises, as discussed under regulation 17, presented infection hazards and risks as it was not sufficiently clean or maintained. In addition, practices such as the inappropriate storage and maintenance of cleaning equipment such as mop heads and dust pans, the laminated pictures in the shower, and in particular the laundry arrangements required improvement. There was mildew and mould around some window frames.

The person in charge had established systems such as risk assessments, monthly infection control audits, cleaning schedules, temperature checks, and self-assessments to reduce the risk of infection transmission and to provide assurances that the measures were in place. However, there were gaps in the recording of cleaning schedules and in the temperature checks. The 'COVID-19 management plan for positive cases' required enhancement as it was not dated or signed, and further detail was required in relation to areas such as staffing, visiting arrangements, and access to PPE.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had established fire safety management systems in the centre. The fire equipment was regularly serviced, and was also checked by staff. However, there was gaps in the records of the daily fire checks, for example, the checklist was not completed for several days in January 2022.

There were arrangements in place for the evacuation of residents in the event of a fire such as, individual personal evacuation plans, and ongoing education with residents about safe evacuation. Fire drills took place twice per year; however, the drills did not demonstrate that the residents could be safely evacuated when there was reduced staff numbers.

The fire doors were inspected and were found to close fully when the self closing devices activated. There was no self closure device on the fire door between the kitchen and utility room. Both rooms are high risk areas for possible fire ignition, and the absence of a self closing device on the door separating them requires consideration.

There was a build up of lint in the tumble dryer that presented as a fire hazard. The arrangements for the removal of lint from the tumble dryer required improvement.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessment of the residents' health, personal and social care needs was carried out. The social care leader had carried out the assessments and ensured that corresponding plans were developed. A small number of personal plans required review such as the money management plan and the clinical communication guidelines.

Additional plans required development based on areas identified in the assessments such mental health and ear care. The written plans were required to clearly outline the supports required by residents in these areas.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge had not ensured that staff had up to date knowledge and skills to respond to behaviours of concern; as discussed under regulation 16, there were

significant gaps in relevant training.

One of the behaviour supports plans was overdue review. In addition, the plan had only been signed by two staff members to indicate that they had read it. This did not provide assurances that staff were delivering support in line with the plan.

The registered provider had not ensured that restrictive practices were implemented with informed consent, or applied in accordance with best practice. While, the use of some restrictions had been approved by the provider's monitoring group approval for others had expired by six months. There was no approval for the restriction on a phone handset, and the rationale for the restriction was unclear.

Residents, or their representatives, had not provided informed consent for all restrictions. In some cases, residents were not aware of the restrictive practices which were referred to as 'undisclosed'. A restrictive practice support plan for one resident was overdue review.

The recording of restrictions was also found to be inconsistent, and therefore did not reflect if restrictions were used for the shortest duration necessary.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had implemented systems to protect residents from all forms of abuse.

A sample of records relating to two allegations were reviewed and indicated that they were managed appropriately and in line with the providers policy on safeguarding residents from abuse. Safeguarding plans were developed where deemed required, and there was also specific guidelines for staff to follow in responding to safeguarding concerns.

Individual personal intimate care plans were in place for residents, to ensure that they were supported in a manner that respected their privacy and dignity.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had the freedom to exercise choice and control in many aspects of their lives, and were supported to engaged in activities meaningful to them. Residents also participated in the organisation of the centre.

However, the ongoing incompatibility issues between the residents resulted in restricted access to their home. In addition, the deficits in the implementation and management of restrictive practices in centre did not uphold residents' rights.
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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Collins Avenue OSV-0005059

Inspection ID: MON-0031443

Date of inspection: 27/01/2022

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: • Recruitment is ongoing within SMH to fill current vacancies • Recruitment is an ongoing process • Management hours to be prioritised on roster for SCL and any impact on same to be escalated to SM on a monthly basis.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All mandatory training completed by all staff • All IPT needs escalated to training department • Training needs reviewed monthly by SCL • Supervision meetings for all staff to continue in line with SMH policy	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Documented management meetings between SCL and SM/PIC to take place every 2 weeks as well as ongoing phone contact. Evidence of meetings to be held in centre. • Supervision in place documentation of same to be held in the DC • Walkaround to be completed by PIC/SM monthly	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose:	

• Statement Of Purpose has been reviewed and updated with accurate information Revision 6 • Date: 02/02/2022

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • There is a timebound plan in place regarding premises to be completed by 29th April 2023 • All works will be addressed as part of timebound plan but in interim identified areas have been highlighted to technical services department to look at interim measures to address. • House agreement in place for residented revised and discussed with residents and for review with PAMG • Structured plans support residents in daily timetables • Cleaning schedules have been revised to include more detail for each room	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Risk Assessment for Visitors developed and in place • Emergency response plans have been reviewed and localized • NCT completed on 25th February 2022.	

Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • Deep Clean has been carried out in house by external company 25th February 2022 • Cleaning schedules have been revised to include more detail for each room • Laundry baskets purchased and laundry guidance in place for staff • Storage of Mop heads and dust pans have been revised • Mildew and mould has been addressed locally and escalated to technical services • Staff team update on recording of cleaning schedules and SCL weekly review in place • COVID management plan to be reviewed and revised ensuring inclusion of areas such as staffing, visiting arrangements, and access to PPE.	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Staff team update on recording of fire checks and weekly review by SCL in place • Night drill simulated to ensure evacuation with reduced staffing carried out on 13th February 2022. • Self closure consideration escalated to SMH fire officer • Staff team update on cleaning of dryer/lint • Admission of lint monitoring to cleaning schedule checklist	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • AON in place for both residents and reviewed annually or as required. • Personal support plans are reviewed every 3 months • Specific plans reviewed in relation to money management, clinical communication guidelines, • Support plans developed in relation to mental health & ear care.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • All staff have completed up to date PBS training • PBS plan updated for resident in question and signed off by all staff • Review of all restrictive practices and documentation to take place with psychology and PAMG in line with SMH Policy on The Use of Restrictive Practices	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Timebound plan in place to alter the environment providing both residents with their own living space removing restricted access. To be completed by 29th April 2023. • Review of all restrictive practices will take place with psychology and PAMG	

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	31/12/2022
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	31/12/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Not Compliant	Orange	30/04/2022

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	29/04/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	29/04/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	29/04/2023
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and	Substantially Compliant	Yellow	29/04/2023

	promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	29/04/2023
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	31/03/2022
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for	Substantially Compliant	Yellow	31/03/2022

	the quality and safety of the services that they are delivering.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/03/2022
Regulation 26(3)	The registered provider shall ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.	Substantially Compliant	Yellow	31/03/2022
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	Not Compliant	Orange	31/03/2022

	prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/03/2022
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/03/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/03/2022
Regulation 28(4)(a)	The registered provider shall 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.	Substantially Compliant	Yellow	31/03/2022
Regulation 28(4)(b)	The registered provider shall	Substantially Compliant	Yellow	28/02/2022

	ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	28/02/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2022
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be	Substantially Compliant	Yellow	31/03/2022

	multidisciplinary.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/04/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/04/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/04/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive	Substantially Compliant	Yellow	30/04/2022

	procedure, for the shortest duration necessary, is used.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	29/04/2023
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	29/04/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and	Not Compliant	Orange	29/04/2023

	personal information.			