Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

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| Name of designated centre: | Aspire Residential Unit |
| Name of provider: | Autism Spectrum Association Of Ireland Company Limited By Guarantee |
| Address of centre: | Dublin 16 |
| Type of inspection: | Announced |
| Date of inspection: | 21 October 2021 |
| Centre ID: | OSV-0001530 |
| Fieldwork ID: | MON-0026673 |

## About the designated centre

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

Aspire residential service provides a residential service for up to three adults with Asperger syndrome in a suburb of Dublin city. The house is located within walking distance of a number of amenities such as shopping centres, a library, restaurants and parks and has good public transport services. The house is a four bed roomed house. Downstairs there are two living rooms, a kitchen, a porch which serves as a conservatory and a bathroom. Upstairs there are two offices, a staff sleep over room and three bedrooms, each of which has an en-suite. There is a garden to the front and the rear of the property. The aim of the service is to provide a high level of individualised support to adults with Asperger Syndrome to enable them to develop their independent living skills, engage with the community and fulfill their personal goals in a caring and safe environment. Supports are tailored to meet residents needs and the service can cater for those who present with co-occurring mental health conditions. Residents are supported on a 24 hour basis by a team of social care workers.

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

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| 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 - 2015 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 21 October 2021 | 10:00hrs to 17:30hrs | Sarah Cronin | Lead |

## What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and as such, the inspector followed public health guidelines throughout the inspection. From what residents told us and what the inspector observed, it was clear that residents in this centre were enjoying a good quality of life and that they were supported to pursue their personal interests and goals. The inspection identified mixed levels of compliance, with improvements required in eight of the regulations inspected against. However, these did not appear to be having a negative impact on the lived experience of the residents in the service. There were numerous examples seen over the course of the day of how residents were being active participants in all aspects of their care and in their home.

The centre is located on a busy road in a Dublin suburb. It is within walking distance of many amenities such as parks, a shopping centre, a library, pubs and restaurants and it was very well served by public transport. This enabled residents to engage in many activities in the locality.The inspector spent time with both of the residents during the day. One of the residents told the inspector about the activities they enjoyed such as astronomy, reading, walking and listening to music. They had recently had improvements made to their room and had their bathroom re-done which they said they liked. They went out for a walk in a local park later that morning. While the resident communicated verbally, at times they chose to use gesture or make choices using written words and the staff facilitated them to do so in a kind and respectful manner. The second resident came and spoke with the inspector in the afternoon. They told the inspector that they had lived in the centre for seventeen years and that they loved living there. They had recently joined a gym and were due to resume classes in a language school over the coming weeks. The resident had a range of interests which included doing their own magazine and learning languages on an app on their phone. They reported that they often went into town on the bus and saw their family every weekend. They spoke about how they set their goals and what they enjoyed doing. They told the inspector about a trip they were taking over the weekend to do a tour which they were looking forward to.

The inspector received questionnaires from both residents which had been circulated to the person in charge prior to the inspection. The questionnaires seeks feedback on different aspects of the residents' experience such as general satisfaction with the service, bedroom accommodation, food and mealtime experience, arrangements for visitors to the centre, rights, activities , staff supports and complaints. Both of the questionnaires indicated that residents were satisfied with the service they were receiving. One of the residents indicated that they felt they had been listened to and accepted when they had made a complaint. Finally, one of the quotes from the resident was "my experience progresses and improves throughout the years".

The inspector viewed a sample of minutes from weekly residents meetings. These had set items such as menu and activity planning. There was also an educational

component to these meetings, for example, one of the meetings covered types of abuse and how to report concerns. These minutes were viewed and signed off by the person in charge. Throughout the day, the inspector saw examples of resident input into different parts of the service such as their care plans and stress management plans and on taking responsibility for the fire evacuation bags on a drill.

In summary, the inspector found that the lived experience of the residents was that they had a good quality of life and that the service supported them to achieve their goals and to pursue their interests. They were both very well presented and at ease in the company of staff. Interactions were noted to be respectful, friendly and kind. As stated earlier in the report, there were a number of areas identified during the inspection which required improvement. The next two sections of the report present the inspection findings in relation to the governance and management of the centre and how these arrangements affected the quality and safety of the service being delivered.

## Capacity and capability

The provider was in the midst of a significant change in staffing at both executive and senior levels in the organisation on the day of the inspection. The CEO was also the person participating in management and also had a management role in the organisation's production company. While there was a clear management structure in place, there was a need for more robust systems and processes to ensure that there was adequate oversight over the quality and safety of the care being provided in the centre. It was evident that the provider had put additional systems and funding in place to improve levels of compliance since the last inspection and all actions which were required on the compliance plan had been completed. There were suitable on call arrangements in place in addition to arrangements for when the person in charge was absent.

Management meetings took place once a week. The CEO and person in charge met informally each day. Monthly board meetings took place. The CEO informed the inspector that board members were available by phone for additional support where required. The provider had completed an annual review and a six monthly review of the service in line with the regulations which included input from residents and their families. At centre level, audits were mainly related to health and safety in areas such as housekeeping, fire, electrical equipment and screen use. Oversight and monitoring systems on other aspects of care such as medication, finances, infection prevention and control and care plans required improvement. Where reviews or audits had taken place, it was unclear if identified actions had been completed. Additionally, some audits which had been completed were inaccurate and had not been checked by the person in charge.

The provider had appointed a person in charge who possessed the required

experience and qualifications to carry out the role. The post was full time. It was clear that they knew the residents well and they spoke with the inspector throughout the day about improvements they were planning to continue to improve the service. The centre was appropriately resourced with a suitable skill mix and number of staff to meet the assessed needs of residents. The actual and planned roster indicated that there was a stable staff team in the weeks prior to the inspection which had a positive impact on the continuity of care being offered to residents. The inspector viewed a sample of staff files and found that all documents required in Schedule 2 of the regulations were present and in date. Staff meetings took place every 6-8 weeks. These did not have a structured agenda in place.

All staff had done mandatory training in a number of areas such as safeguarding, fire safety and first aid. They had also completed a number of courses relating to infection prevention and control such as hand hygiene and donning and doffing personal protective equipment (PPE). All staff had completed a course on the safe administration of medication online. However, there was no competency based practical assessment of skills prior to administering medication. This required improvement. There was a clear induction for new members of staff. Supervision arrangements had been put in place for staff since the last inspection, with sessions occurring every two months. However, the inspector found that these sessions did not have a clear structure and where it was required, did not address performance issues with staff members. The CEO did not have formal supervision arrangements in place on the day of inspection. The provider had also introduced a performance management system since the last inspection which was in progress and due to be carried out annually with all staff.

The provider had notified the office of the Chief inspector on incidents relating to residents within the required time frames. However, there were a number of changes in personnel at senior management level in addition to a change in the company name which had not been notified as required. The provider had submitted these retrospectively on the day of inspection. A number of the policies required in Schedule 5 of the regulations were found to be out of date. However, the provider informed the inspector that they were in the process of updating all policies to ensure they were in date and in line with best practice.

In summary, the provider had implemented a number of changes since the last inspection which had increased their levels of compliance with the regulations but systems of oversight and documentation continued to require improvement.

## Regulation 14: Persons in charge

The provider had appointed a suitably qualified and experienced person in charge. They were full time and had good knowledge of the residents and their needs.

Judgment: Compliant

## Regulation 15: Staffing

The centre was adequately resourced and had a stable staff team in place with no use of agency in the weeks prior to the inspection. The inspector reviewed a sample of staff files which indicated that Schedule 2 documents were in place and in date.

Judgment: Compliant

## Regulation 16: Training and staff development

All staff had done mandatory training in a number of areas such as safeguarding, fire safety and first aid. Staff were completing a medication management course online. However, there was no competency based practical assessment of staff skill prior to administering medication. This required improvement. Supervision arrangements had been put in place for staff since the last inspection, with sessions occurring every two months. However, the inspector found that these sessions did not have a clear structure and where it was required, did not address performance issues with staff members. The CEO did not have formal supervision arrangements in place on the day of inspection.

Judgment: Substantially compliant

## Regulation 22: Insurance

The provider furnished the inspector with a copy of their insurance which met requirements of the regulations.

Judgment: Compliant

## Regulation 23: Governance and management

While there was a clear management structure in place, there was a need for more robust systems and processes to ensure that there was adequate oversight over the quality and safety of the care being provided in the centre. It was evident that the provider had put additional systems and funding in place to improve levels of compliance since the last inspection, with all required actions completed.

Management meetings took place on a weekly basis. The CEO and person in charge

met informally each day. Monthly board meetings took place. The provider had completed an annual review and a six monthly review of the service in line with the regulations which included input from residents and their families. At centre level, audits mainly related to health and safety such as housekeeping, fire, electrical equipment and screen use. Oversight and monitoring systems in relation to aspects of care such as medication, finances and risk management required improvement. Where reviews or audits had taken place, it was unclear if identified actions had been completed. Additionally, some audits which had been completed were inaccurate and had not been checked by the person in charge.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The provider's statement of purpose contained all information required by the regulations.

Judgment: Compliant

## Regulation 4: Written policies and procedures

Some of the provider's policies and procedures were out of date such as the policy on resident's personal properties, finances and possessions. These were in the process of being reviewed.

Judgment: Substantially compliant

## Quality and safety

The inspector found that residents were in receipt of a good quality service which promoted their rights and encouraged them to pursue their interests. The inspector viewed the residents' person centred support plans. These were reviewed annually and where needs were identified, there were corresponding care plans in place. These plans included positive stress management plans which had been developed with the residents in addition to clear guidance on supporting communication with each resident. There were a very small number of restrictions in this centre which were well documented and had input from the residents' GP. Residents met with their key workers regularly and reviewed their goals and planned tasks to achieve their goals. One of the residents told the inspector about how they set their goals

with their key worker and what their goals were.

Residents were supported to enjoy best possible health. There was evidence of input from a range of health and social care professionals such as psychiatry, psychology, occupational therapy and dentistry. There was a record of any appointments which residents attended with the outcome and any required actions to be taken. Residents were supported to be independent in attending their appointments where appropriate. The person in charge had introduced monthly health observations to the centre to ensure that residents were appropriately cared for.

Risk management systems had improved somewhat since the last inspection. The policy had been updated to meet regulatory requirements. There was a safety statement in place and the provider had done a risk register since the last inspection, with risk assessments reviewed on a quarterly basis. However, there was no evidence that risk was being reviewed at provider level to ensure adequate oversight.

The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. This was regularly reviewed. There was information readily available to staff and residents on COVID-19 and this was found to be up to date. There was a lead worker representative identified in the centre in relation to COVID-19. Temperature checks were carried out twice daily on residents and staff and logged. There were adequate facilities in place for hand hygiene in the centre. Clear cleaning schedules were set up for each room with tasks to be done daily, weekly and quarterly. There was appropriate systems in place for waste management in the event of a COVID-19 outbreak. Water checks or regular running of water did not appear to be recorded for the unused en suite bathroom in the centre. Audits were not carried out relating to infection prevention and control to ensure adequate oversight of this at centre level.

The provider had made significant improvements to fire safety management systems in the centre since the last inspection. Fire detection and containment systems and fire fighting equipment were in place. The provider had added a number of fire door retainers and had put additional emergency lighting in place since the last inspection. Servicing and maintenance records were viewed and in date. Personal emergency evacuation plans had been updated. Fire drills were well documented with clear actions identified where required. These indicated reasonable evacuation times and residents both told the inspector what they would do in the event of a fire. Different scenarios were being used on each drill. One of the residents was involved in making signage in relation to fire. Grab bags had been put at both entrances.

Medication management in the centre required improvement. The incident and accident log outlined a number of errors which had taken place in 2021. There was a medication reporting form in place but it was not evident what actions were

immediately taken on some forms and there was not evidence of learning from adverse events. Where staff members had made a number of errors, this was not addressed formally in supervision. There was a quarterly review of medication errors taking place, but no record if actions had been addressed or not. The person in charge reported that staff had completed online training only in the safe administration of medication, with no competency based assessment. They self-identified this as an issue and were in the process of seeking additional training to carry out assessments with staff. Both residents had assessments in place for the self-administration of medication. One resident had a protocol in place for storing and taking their medication. While there was a protocol in place to release the medication with the resident, there were not appropriate measures in place to ensure the medication administration record was appropriately completed. The resident's medication was not stored in a locked press in their room. The system for ordering and receipt of medication was adequate although audits required improvement. For example, two audits had taken place in the months prior to the inspection. Both of these indicated that there were no out of date medication in the press. However, when the inspector viewed this press, there was some medication which was significantly out of date. Out of date medication and PRN which was no longer required was not stored separately to other medication.

The provider had appropriate measures in place to ensure residents were safeguarded from abuse.The provider had appropriate systems in place to ensure that residents were safeguarded from abuse. They had an up to date policy in place which was in line with national guidance. Staff had completed training and residents were informed about safeguarding and recognising abuse in residents' meetings. Staff with whom the inspector spoke to were knowledgeable about the process for reporting any safeguarding concerns. Residents reported feeling safe and happy.

## Regulation 17: Premises

On the whole, the centre met the aims and objectives of the service and was appropriate to meet the residents' needs. It is an old two storey house located on a busy road. The centre was nicely decorated throughout and residents' rooms were reflective of their interests. Both residents had recently had works done to improve their bedrooms, with additional vents being put in place, mould treated, en suites upgraded and re-painted. Some areas of the house required maintenance and repair in order to retain the homely, pleasant appearance of the residents’ home such as cracked tiles in the bathroom downstairs and a crack in the wall outside a residents bedroom. For the most part the centre was found to be clean. However, there were some cobwebs on the ceiling upstairs near a fire alarm and in some corners of the ceilings. The shower and sink in the en suite bedroom which was vacant were dirty. All other areas were found to be clean and in a good state of repair.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

Risk management systems had improved somewhat since the last inspection, however oversight at provider level required improvement. There was a safety statement in place and the provider had done a risk register since the last inspection, with risk assessments reviewed on a quarterly basis. The policy had been updated and met regulatory requirements. While the register was in place, there was not a record of risk being discussed at provider level to ensure adequate oversight. The register did not include risks at provider level.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. This was regularly reviewed. There was information readily available to staff and residents on COVID-19 and this was found to be up to date. There was a lead worker representative in relation to COVID-19. Temperature checks were carried out twice daily on residents and staff and logged. There were adequate facilities in place for hand hygiene in the centre. Clear cleaning schedules were set up for each room with tasks to be done daily, weekly and quarterly. There was appropriate systems in place for waste management in the event of a COVID-19 outbreak. Water checks or the running of water in the unused en suite bathroom did not appear to be recorded. The sink and shower were dirty and required attention. Audits were not carried out relating to infection prevention and control to ensure adequate oversight of this at centre level.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

The provider had made significant improvements on the fire safety management systems in the centre since the last inspection. Fire detection and containment systems and fire fighting equipment were in place. The provider had added a number of fire door retainers and additional emergency lighting in place since the last inspection. Servicing and maintenance was in place as were daily checks. Personal emergency evacuation plans had been updated. Fire drills were well documented with clear actions identified where required. These indicated reasonable evacuation times and residents both told the inspector what they would do in the

event of a fire. Different scenarios were being used on each drill. One of the residents was involved in making signage in relation to fire. Grab bags had been put at both entrances.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

Medication management in the centre required improvement. The incident and accident log outlined a number of errors which had taken place in 2021. There was a medication reporting form in place but no evidence of learning from these adverse events. Additionally, there was not evidence of these issues being addressed in supervision for the relevant staff members. There was a quarterly review of medication errors taking place, but no record if actions had been addressed or not. The person in charge reported that staff had completed online training only in the safe administration of medication, with no competency based assessment to ensure they had the practical skills required to administer medication safely. Protocols in relation to supporting residents to self administer medication and the storage of this medication required attention.The system for ordering and receipt of medication was adequate although audits required improvement. For example, two audits had taken place in the months prior to the inspection. Both of these indicated that there were no out of date medication in the press. However, when the inspector viewed this press, there was some medication which was significantly out of date.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

The inspector viewed the residents' person centred support plans. These were reviewed annually and where needs were identified, there were corresponding care plans in place. Residents met with their key workers regularly and reviewed their goals and planned tasks to achieve their goals. These plans included positive stress management plans which had been developed with the residents in addition to clear guidance on supporting communication.

Judgment: Compliant

## Regulation 6: Health care

Residents were supported to enjoy best possible health. There was evidence of

input from a range of professionals such as psychiatry, psychology, occupational therapy and dentistry. There was a record of any appointments which residents attended with the outcome and any required actions to be taken well documented. Residents were supported to be independent in attending their appointments where appropriate. The person in charge had introduced monthly health observations to the centre to ensure that residents were appropriately cared for.

Judgment: Compliant

## Regulation 8: Protection

The provider had appropriate systems in place to ensure that residents were safeguarded from abuse. They had an up to date policy in place which was in line with national guidance. Staff had completed training and residents were informed about safeguarding and recognising abuse in residents' meetings. Staff with whom the inspector spoke to were knowledgeable about the process for reporting any safeguarding concerns. Residents reported feeling safe and happy.

There were assessments in place in relation to what level of support each resident needed to manage their finances and their medication. There was a documented protocol in place for supporting each resident with their finances and what was required. Intimate care plans were drawn up where required with input from residents. This was noted to be written in person centred language which was respectful of the residents needs and rights to privacy.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 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 | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Not compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Aspire Residential Unit OSV-0001530

## Inspection ID: MON-0026673

## Date of inspection: 21/10/2021

**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 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>All staff are fully trained in Safe Administration of Medication.<br>Following the HIQA Inspection, the PIC has undergone Competency Based Practical Training on the 01.11.2021.<br>Competency based assessment tools are currently being developed, to reflect our residential center, this will be rolled out by 01.12.2021. All staff will have to pass their medication competencies and their medication training before they can administer medication. In addition to the initial assessment, staff will be assessed annually.<br><br>Our Support and Supervision document now includes a section on performance review, that is structured to reflect and gain learning on any incidents and medication errors. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>Currently we are carrying out a number of audits in house. We have updated our site safety audit. We are in the process of updating our medication audit, which will be completed by the 30.03.2022. We are creating an infection, prevention and control audit, this information will carry across the 12 weekly Covid Self-Assessment tool. This auditing tool will be in place by 31/12/2021 | |

We will develop additional auditing tools in the area of leadership and governance and risk management. These will be completed by the 30.06.2022

Once all auditing tools are developed, they will be added to our auditing calendar to ensure completion.

A clear action tracker will be added to each audit tool, which will be signed off by the PIC and or Provider.

Team meetings now include a more structured agenda. Including risk management, COVID-19, health and safety, Key working updates, incidents and accidents and audit updates.

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| Regulation 4: Written policies and procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All policies throughout the residential center will be reviewed, updated and brought into line with each other. A plan has been put in place for the provider and the PIC to complete 2 to 3 polices per month.

Polices which are out of date will be completed first, these include: Residents personal property and finances and possessions. Both of these policies will be completed by the 31.12.2021.

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|---|---|
| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
When the finances are next available, we will carry out renovations on the bathroom downstairs. In the meantime, we will obtain three quotes for said work. All quotes will be obtained by 01.04.2022.

A deep clean has been carried out on the spare room including the en-suite, more specifically the shower, sink and toilet. Monthly deep cleaning of this room has also been added to the monthly cleaning tasks.

Higher level dusting has also been added to cleaning schedules.

Building contractors inspected the crack on the wall outside the resident's bedroom on the 19.11.2021. The findings and the report are yet to be returned. Once received funding will need to be secured to carry out works. Safety of the residents will be paramount in any decision making.

| Regulation 26: Risk management procedures | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Site safety audits are currently being carried out. This document has been updated to include a more comprehensive assessment of the center. The frequency of these audits have been increased from biannually to monthly.

An audit tool is being developed on risk management and will be implemented by 30.06.2021.

Risk has now been added as a topic on the agenda of the inhouse team meeting. Any significant risk findings will be brought by the provider to the Board members for discussion.

Provider level risks will be added to the register, this will include a number of risk assessments being carried out. This will be completed in full by 30.06.2022

| Regulation 27: Protection against infection | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Water checks are being carried out weekly, a template has been created to be signed off by staff on completion, this additional duty has been added to weekly household tasks.

A deep clean has been carried out on the spare room including the en-suite, more specifically the shower, sink and toilet. Monthly deep cleaning of this room has also been added to the monthly cleaning tasks.

An infection, prevention and control audit tool will be created and added to the Audit monthly calendar which will be signed off by the PIC, this information will carry across the 12 weekly Covid Self Assessment tool. This auditing tool will be in place by

31/12/2021.

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|---|---|
| Regulation 29: Medicines and pharmaceutical services | Not Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Competency based assessment tools are currently being developed, to reflect our residential center, this will be rolled out by 01.12.2021. All staff will have to pass their medication competencies and their medication training before they can administer medication. In addition to the initial assessment, staff will be assessed annually.

The PIC is currently assessing the environment and actions the are considered the norm at the time before, during and after medication administration. Areas for improvement or change are being considered, the PIC is relaying any adjustments to the team.

Our Support and Supervision document now includes a section on performance review, that will be structured to reflect and gain learning on any incidents and medication errors.

The PIC is now reviewing each medication error form with the staff member involved. Providing a space for reviewing actions taken, open communication and problem solving. All learning will be documented with staff before signing off.

An additional section has been added to our quarterly medication reviews document. To record any actions that need to be taken, how we plan to do it, who is responsible, the time frame it will be completed in and a sign off section once complete.

The resident who is self-administering their PM medication is receiving the medication in a sealed box. This sealed box is stored in a dedicated location of the resident's room. Staff and resident sign the medication release form together. The resident has been given an additional sign off sheet in the sealed box, to sign once they have self-administered. An alarm is set to go off at administration time and staff check in with resident 15 minutes after resident is due to have self-administered PM medication.

Current medication audit template is still in use, the PIC is reviewing each medication audit form before signing off, a new medication audit template will be developed and implemented by 30.03.2022. In addition, the PIC will be reviewing all forms related to medication including medication returns, medication errors and Mars sheets. This will also be completed by 30.03.2022.

## 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 |
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| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 01/12/2021 |
| Regulation 17(1)(c) | The registered provider shall ensure the premises of the designated centre are clean and suitably decorated. | Substantially Compliant | Yellow | 31/01/2022 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Substantially Compliant | Yellow | 30/06/2022 |
| Regulation 23(3)(a) | The registered provider shall ensure that effective arrangements are in place to support, | Substantially Compliant | Yellow | 30/06/2022 |

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| | develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. | | | |
| 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 | 30/06/2022 |
| 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 prevention and control of healthcare associated infections published by the Authority. | Substantially Compliant | Yellow | 31/12/2021 |
| Regulation 29(4)(a) | The person in charge shall | Substantially Compliant | Yellow | 01/12/2021 |

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| | ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely. | | | |
| Regulation 29(4)(b) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident. | Substantially Compliant | Yellow | 01/12/2021 |
| Regulation 29(4)(c) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal | Not Compliant | Orange | 01/12/2021 |

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| | and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance. | | | |
| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice. | Substantially Compliant | Yellow | 31/12/2021 |