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: | Ard na Greine |
| Name of provider: | Sunbeam House Services Company Limited by Guarantee |
| Address of centre: | Wicklow |
| Type of inspection: | Unannounced |
| Date of inspection: | 04 May 2023 |
| Centre ID: | OSV-0001689 |
| Fieldwork ID: | MON-0039911 |

## About the designated centre

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

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

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

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| Number of residents on the date of inspection: | 4 |

## 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 4 May 2023 | 10:00hrs to 17:45hrs | Jacqueline Joynt | Lead |

## What residents told us and what inspectors observed

This report outlines the findings of an unannounced risk-based inspection of this designated centre.

On the day of the inspection, the inspector was provided with the opportunity to meet and speak with two of the four residents living in the centre. While some of the residents spoke with the inspector, not all residents provided their views on the service they were in receipt of. Through-out the day, the inspector also spoke with the senior service manager, the person in charge, deputy manager and staff. A review of documentation and observations, were also used to inform a judgment on residents' experience of living in the centre.

On the day of the inspection, the inspector was informed that one of the residents was spending time abroad with a family member. Another resident was in the process of transitioning into the centre on a full-time basis and was currently availing of the service two days per week; the transition was moving at a pace that met the resident's assessed needs. The two other residents living in the centre spend the day in their home during the inspection and in the afternoon, one of the residents headed out to enjoy a community activity (a computer course) provided by a local community service.

During late morning, one of the residents sat outside in the back garden and spend time talking with the inspector about their lived experience in the centre. The resident had been offered a new job that day and explained to the inspector about the work and effort they had put into getting the job. They had submitted a lot of CV's into local employers and were very happy to have received the offer of the job. The resident told the inspector that they were looking forward to talking to a particular staff member about their new job.

Overall, the resident told the inspector that they enjoyed living in the centre however, there were a few matters that were impacting on their lived experience. The resident advised the inspector that there had been a lot of change in the centre. The resident spoke about the amount of different and unfamiliar staff working in the centre and expressed how, at times, it had raised their anxieties. They said that while they enjoyed spending time and going for coffee with familiar staff, some of who were agency staff, they were at times concerned about the care and support provided to them by unfamiliar staff.

The resident also spoke briefly about their relationship with other residents in the house. Overall, they were happy with who they were living with however, there were times where other residents' behaviours had upset them. The resident informed the inspector that the they used to attend weekly counselling sessions. They expressed that they found the sessions to be helpful and beneficial when they wanted to talk about something that was upsetting them. The resident informed the inspector that the counselling service was no longer available to them and that they

missed it.

In the front sitting room of the house, the inspector met with another residents. The inspector spoke briefly with the residents while observing them colouring in pictures in a mindfulness art book. The resident appeared to enjoy the activity and showed the inspector some of the colouring-in pictures they had completed. The inspector was informed by staff that they had suggested a community activity to the resident but they had declined. They expressed to the inspector, that they were not in the mood for going out that day. The resident appeared happy and comfortable in their environment and with the staff supporting them. On review of the resident's daily logs, the inspector saw that the resident had not attended, (by choice), their day service for a long period of time. The resident was frequently staying in their home colouring and regularly declined offers of community activities.

There had been an increase of behavioural incidents occurring in the centre which had resulted in alleged safeguarding incidents there had been other staffing safeguarding concerns also. Safeguarding plans had been put in place in an effort the reduce the risk of incidents reoccurring. Residents were assisted and supported to develop their knowledge, self-awareness and understanding and skills needed for self-care and protection. In addition, residents were provided with individual safety plans that included easy-to-read information on what the different forms of abuse were and how to protect themselves in their home and community from abuse.

The design and layout of the premises ensured that each resident lived in an accessible, comfortable and homely environment. This enabled the promotion of independence, recreation and leisure in the house. The inspector observed the physical environment of the house was bright and for the most part clean. However, in one of the upstairs communal bathrooms the inspector observed two healthcare waste bins to be full to capacity. This posed a potential inflectional control risk to residents and staff using the bathroom.

In summary, through speaking with residents, management and staff and through observations and a review of documentation, it was evident that the provider and person in charge were striving to ensure that residents lived in a supportive and caring environment.

Since the previous inspection, there had been an increase of safeguarding incidents occurring in the house, which, at times, resulted in negative outcomes for some residents. The effectiveness of the strategies and initiatives, previously implemented to address compatibility issues in the house, had not been sustained. Overall, due to the current arrangements in place for staffing, governance and management and behavioural supports, the inspector found that the risk of peer to peer safeguarding incidents occurring in the house remained.

This is discussed in the next two sections of the report which presents the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impact on the quality and safety of the service being delivered to each resident living in the centre.

## Capacity and capability

This risk-based unannounced inspection was completed due to the increase in solicited notifications of alleged safeguarding peer to peer incidents in the preceding months and the submission of unsolicited information to the Health Information and Quality Authority (HIQA). The provider was issued with a provider assurance report which they completed, and for the most part, satisfactory assurances were provided.

Previous to this inspection two risk-based inspections had been carried on in the centre in June and November 2022; the June inspection found poor levels of compliance for a number of regulations and subsequent to the inspection the provider was required to attend a warning meeting with HIQA. At the meeting the provider was issued with a warning letter advising that if the designated centre did not come back into compliance it may result in further escalation or enforcement action by the Chief Inspector.

The inspection of the designated centre in November 2022 found that the provider had made a number of improvements since the June 2022 inspection, which had resulted in positive outcomes for residents.

However, on the day of this inspection, the inspector found that a number of the improvements had not been sustained and that regulation 15 remained non-compliant. There was a high dependency on external agency staff, which overall was impacting on continuity of care for residents. In addition, a number of the local governance and management systems in place, relating to the oversight and monitoring of the centre, required improvement to ensure their effectiveness at all times. Overall, systems in place to ensure smooth and effective service delivery for residents, were not always adhered to and at times, resulted in negative outcomes for residents.

The current staffing arrangements in place were not always meeting the needs of the residents living in the centre. In addition, they were not in line with the statement of purpose. Due to staff vacancies and specific staff leave vacancies, there was a continued reliance on agency staff which further increased in March and April 2023. There were seven agency staff included on the roster and while some agency staff had become familiar to residents, others had not. Where staff were not familiar to residents, this increased the potential risk of behavioural incidents occurring in the centre and for some residents, raised their anxieties.

Agency staff were not included in staff team meetings, or provided with the centre's supervision or performance development meetings. However, the person in charge had put systems in place in an effort to better guide and support agency staff in their practice and in particular, to become more familiar with the needs of the residents and the supports required to meet those needs.

The person in charge and deputy carried out inductions for all new external agency

staff. There was a comprehensive handover folder in place to specifically support agency staff knowledge and awareness of the resident's needs and care planning in place in place for them. The handover document also included matters relating to the day to day running of the centre, local and senior management contacts including on-call details. In addition, agency staff had been provided access and shown how to use the computerised system in place where the most up-to-date information relating to the residents care and support was recorded and reviewed. However, improvements were needed to the monitoring and oversight of some of these system to ensure their effectiveness.

The provider had completed an annual review of the care and support provided in the designated centre between December 2021 to December 2022 and had ensured that residents and their family were consulted about the review.

Senior management met with the person in charge on a regular basis to discuss matters relating to the operation of the centre and matters concerning residents. The person in charge, supported by the deputy manager and staff, completed a suite of audits on a monthly basis. The array of audits included staff knowledge checks, housekeeping audits, petty cash audits, personal plan document audits, mediation and pharmacy audits and health and safety audits, but to mention a few. On review of some of the audits and checklists in place, the inspector found that not all audits were effective. As a result, an infection prevention and control risk, that was identified by the inspector on the day of the inspection, had not been identified or addressed on three different auditing/checking systems in place.

The person in charge and deputy manager divided their hours between this centre an one other. The person in charge was responsible, at local level, for the effective governance, operational management and administration of two centres. On a daily basis, either the person in charge or deputy were required to pay an on-site visit to the other centre they were responsible for.

Overall, due to the complex needs of residents living across the two services, the inspector found that a review of local management's capacity to continue to divide their time between both centres was required to ensure effective service delivery oversight, supervision arrangements for staff and to promote positive outcomes for residents at all times.

However, it was noted that the provider had already self-identified the requirement to review the local operational management arrangements in the centre and had a draft plan in place which would result, if implemented, in greater operational management and oversight of the centre on a daily basis.

## Regulation 15: Staffing

The provider had put in place a number of initiatives and strategies in an effort to recruit new staff. This included a number of open days, recruitment fairs as well as recruitment drives in different parts of the UK. The provider ran recruitment

advertisements on local radio and multimedia forums. The inspector was advised by senior management of the plans in place for their HR team to work alongside some of the organisations' residents to attend open college days in an effort to promote the service and recruit new staff.

The roster was maintained appropriately. On review of a sample of rosters, the inspector saw that there were seven agency staff employed in the centre. Since January 2023, there had been a continuing increase of agency staff employed. This was to cover three vacant social care worker positions and the two staff specific leave vacancies. While the rosters demonstrated that some agency staff worked continuously, this was not the case for all staff and as a result, was impacting on continuity of care and potentially increasing the risk of anxiety and behavioural incidents occurring for some residents.

The designated centre staffing arrangements included loan working which meant that one staff was on shift at any time. During week the person in charge and/or deputy primarily worked on-site in the designated centre's office however, at weekends there was no management working on-site. The roster demonstrated that during a period in March and April 2023 there were a number of weekends where only agency staff were employed. The actual an planned roster for May, demonstrated that while core staff worked on some Sundays, it was primarily agency staff working on Saturdays. On the day of the inspection, the person in charge advised the inspector, of plans to change the shift patterns in place, with the potential outcome of less agency staff working at weekends.

There was a specific folder for agency staff in place which included protocols and procedures for the day-to-day running of centre as well as guidance of support in place to meet the needs of the residents. Many of these included task checklists and signing sheets. In addition, agency staff had been provided with training and written guidance on how to use the computerised system in place that included the most up-to-date information about residents need and supports. However, to ensure that the folder was an effective tool at all times, better oversight of the tasks to be completed, was needed.

Judgment: Not compliant

## Regulation 23: Governance and management

Despite endeavouring to recruit staff, as of the day of the inspection, the provider had not ensured that the centre was adequately resourced. There was a high reliance on agency staff who were not always familiar to the residents.

Improvements needed to local management oversight and monitoring of some of the governance and management systems in place including systems for oversight of staffing. For example:

- Staff daily handover documents were not being completed at all times. The

inspector was provided documentation that demonstrated only two documents had been completed since March 2023. These documents included information regarding residents' appointments, finance, medications, and local checks to be completed. This oversight had not been identified by other local governance and management auditing systems in place.

- Agency staff were supported with training and guidance notes on how to complete daily notes on the internal shared computer system. However, on review from a sample of notes for one resident, (handwritten and on computer), the inspector found that a number of days had not been recorded. This also had not been identified by other local governance and management auditing systems in place.

- An infection prevention and control risk observed by the inspector on the day, had not been identified on a number of audits that had recently been completed. For example, the household audit, cleaning list, daily bathroom check list and daily duties list, had all noted the bathroom as clean, with no health and safety issues.

Overall, a review of local management's capacity to continue to divide their time between both centres was needed. Subsequent to the inspection, the provider approved a business case for the restructuring of the local management arrangements in place.

Judgment: Substantially compliant

## Quality and safety

The inspector found that since the last inspection, the governance and management arrangements as well as the staffing arrangements, to support the delivery of a quality and safe service in the centre, were not always effective. This was impacting on the quality and safety of care and support provided to residents living in the centre and there had been a notable deterioration in compliance levels found on this inspection from the previous inspection.

In addition, not all residents were provided supports to meet their changing needs in a timely manner. Overall, this meant that there were times, where the lived experience of residents in their home resulted in negative outcomes for them. Furthermore, on the day of the inspection, the inspector observed an issue which presented as a risk to infection prevention and control (IPC) measures in place.

The monitoring and oversight arrangements that were in place to ensure the effectiveness of the IPC measures in place required review. While there were a number of household audits and bathroom daily checking systems in place, overall they were not effective at all times. As a result, two healthcare waste bins were found to be full to capacity, with the lid on one bin not closing down due to overflow. This posed an increased risk of the spread of health-care associated

infectious decease to residents and staff using the bathroom.

The inspector reviewed a sample of personal plans and found, for the most part, residents had up-to-date personal plans which were continuously developed and reviewed in consultation with the resident, relevant keyworker, and where appropriate, allied health care professionals and family members. The plans reflected the residents' continued assessed needs and outlined the supports required to maximise their personal development in accordance with their wishes, individual needs and choices.

From a review of associated plans and daily notes and from speaking with staff and through observations on the day, the inspector found that not all residents were provided with adequate choice and options to support them access to facilities for occupation and recreation, opportunities to participate in activities in accordance with their capacities and development needs; and supports to develop and maintain personal relationship and links with the winder community.

Some of the residents living in the designated centre presented with complex needs and were provided access to a range of multi-disciplinary supports to help them manage their behaviours including psychology, psychiatry and behavioural therapy. On review of one resident's positive behavioural plan, the inspector found that there was insufficient evidence to demonstrate that the plan had been reviewed or updated since it was developed in 2020. Additional guidance protocols to guide staff on how to best support the resident manage their behaviours, (during certain scenarios), had been included in the residents personal plan. However, there had been no appropriate allied health professional over site of the protocol plans.

Where there had been recent changes to residents assessed needs, or where certain support services had been withdrawn, the person in charge had made a referral, on the behalf of the residents, to the organisation's behavioural support service. However, as of the day of the inspection, there was no response or appointments provided. This meant that the behavioural supports needs of all residents were not been addressed in a timely manner.

During the last inspection, it was found that there had been a decrease in behavioural incidents occurring in the centre. While compatibility issues had remained, a number of strategies and initiatives had been put in place and as a result there had been a reduction to frequency of peer to peer safeguarding and behavioural incidents. However, this was not sustained and from January 2023 to the day of the inspection, there was a significant increase in alleged safeguarding incidents in the house.

The provider had followed up on resident or staff related safeguarding allegations that had occurred in the centre and on the day of the inspection, internal investigations and processes were on-going with staffing arrangements put in place while investigations were underway. Alleged safeguarding incidents had also been referred and notified to the relevant stakeholders and, where appropriate, safeguarding plans had been put in place in an effort to reduce the risk of safeguarding incident reoccurring.

However, some of the safeguarding plans included supports from allied health professionals such as counselling and behavioural support services, which were not currently in place for residents.

Overall, the inspector found that the current arrangements in place for staffing, behavioural and counselling supports and oversight of some of the care and support systems in place for residents, meant that there was a potential risk of the continuation of compatibility issues occurring in the house, resulting in negative outcomes for residents.

## Regulation 13: General welfare and development

Some residents were provided with supports to assist them have meaningful participation and inclusion in their local community. For example, one resident attending a day service and two other residents were supported by job coaches to support them seek employment in the community. Most residents were also taking part in courses run by the provider or by other community services.

However, not all residents' general welfare and development was promoted in a way that ensured meaningfulness or community inclusion in their daily life.

A resident who was in receipt of full-time day-service pre-admission to the centre, was no longer availing of the service. In November 2022, contact was made between the day service and designated centre in an effort to support the resident to return to the service and to ascertain, the resident's wishes and preferences so that the most appropriate service could be provided for them. However, there was no further follow-up between the services until April 2023. In late April arrangements had been made for the organisation's personal outcomes planner to meet with the resident in an effort to ascertain and plan goals that were meaningful to them for 2023, however, this was in the initial stages of development.

This meant that the resident's wishes and preference were not appropriately explored or, in a timely manner. The resident had not been provided opportunities to engage in other facilities for occupation, recreation or education or any other activities that may of promoted meaningfulness and independence in the resident life during the aforementioned period.

In addition, on review of a sample of the resident’s daily notes, the inspector saw that a high proportion of the resident's time was spend on-site in the centre and was increasing withdrawing from engaging in community activities, and in particular, meaningful activities.

Furthermore, incident logs demonstrated that there had been a change in the resident's behaviours during that latter part of this time. A referral was made to the behavioural support specialist March 2023 however, as on the day of the inspection, no appointment had been provided.

Judgment: Not compliant

## Regulation 27: Protection against infection

During the late morning of the inspection, an infection control risk was identified by the inspector. In a communal bathroom the inspector observed two bins, which contained healthcare risk waste, to be full to capacity. On one of the bins the lid was not closing fully due to the fullness of the bin. The systems in place to monitor the bins was not effective in ensuring they were emptied when needed.

On the day, when this was brought to the attention of local management, the external contractors were called however, they were unable to change the bins until two days' time. This meant that the risk of the spread of health-care associated infectious decease to residents and staff using the bathroom would continue for two more days.

By the later part of the afternoon, senior management personnel removed the bins and replaced them with an empty bin. A similar situation with healthcare waste bins had occurred in another designated centre (run by the same provider) in July 2022. This demonstrated a lack of shared learning and reflective practice between the two centres.

By the end of the day, while the bins had been removed, there was no satisfactory or definitive plan in place to ensure the same situation did not occur again.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

There had been an increase of safeguarding incidents in the house in recent months. In addition, there had been an increase in reliance of agency staff working in the centre. During this period there had been some new behaviours of concern arising for one resident. The person in charge had made referrals for two residents living in the centre for behavioural support input however, there had been no response, plan or timeline to the referral.

Since July 2022, a referral had been made for another resident to support them with their anxieties around some of the incidents occurring in the house. Furthermore, in-house counselling supports, that were in place for the resident, had been withdrawn since December 2022 with no replacement of another service.

As such the provider and person in charge were not ensuring that where residents behaviour necessitated intervention, that every effort had been made to identify and

alleviate the cause of the resident behaviours.

Where there was behavioural support plans in place, the inspector was advised by the person in charge, that they had not been reviewed by the appropriate professional since January 2020.

The person in charge had developed a number of protocols to guide staff on how to best support a resident's behaviour in a number of different likely scenarios. These had been typed up and signed by the person in charge. In addition, there was a signing sheet for staff to complete once they had read and understood each protocol. However, while the protocols referred to the 2020 positive behavioural support plan and risk assessment in places, there was addition information contained the protocols that had no oversight, or been reviewed, by an appropriate allied health professional.

Judgment: Not compliant

## Regulation 8: Protection

Resident were provided with safeguarding passports and were supported to be knowledgeable in how to keep them self safe and aware of how to protect themselves.

However, there were ongoing safeguarding incidents occurring in the centre for example, alleged peer-to-peer incidents of psychological abuse, where a resident's behaviour impacted negatively on another resident and staff related alleged safeguarding incidents had also been investigated.

These alleged incidents had been notified as required however, some of the notifications had not been submitted to HIQA within the required three days and of those submitted some were retrospective allegations.

The inspector noted alleged safeguarding incidents had been followed up appropriately and preliminary screenings had taken place and interim safeguarding plans had been put in place.

Where further information was required by external services, there person in charge followed up promptly and provided the required information. Where allegations related to staff, the provider had put in place the appropriate internal trust in care investigation processes in place and staffing arrangements implemented.

Some improvements were required to ensure the effectiveness of the safeguarding plans and in particular, to support the reduction of compatibility issues. For example, some of the actions identified in safeguarding plans included providing access to support services such as behavioural and counselling supports however, these were not fully in place at the time of inspection.

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| Staff had been provided with training in safeguarding vulnerable adults however, refresher training in safeguarding vulnerable adults was outstanding for three members of the staff team. |
| Judgment: Substantially compliant |

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

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Not compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Not compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Ard na Greine OSV-0001689

## Inspection ID: MON-0039911

## Date of inspection: 04/05/2023

**Introduction and instruction**
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Not Compliant |

Outline how you are going to come into compliance with Regulation 15: Staffing:
The Provider implemented the below strategies in relation to the recruitment of staff.
• Regarding recruitment, the Provider ran an open day on the 8th of November 2022. SHS. Three open days had been organised in 2023 as follows:
Dublin: Saturday: 25th March
Glasgow: Saturday 22nd April
Manchester Thursday 18th May
• SHS ran recruitment advertisements on local radio and multimedia formats in November 2022.
• Recruitment advertisement campaign implemented in March 2023. Advertisement place in online recruitment agencies
• The Human resource department is attending college Open Days in 2023.
PICs and clients have been attending local schools and college as follows:
• Presentation with second year social care students on the 21st March.
• Presentation on 4th May with Older and Disability Social Care degree course.
• Presentation on 2nd May with 5th and 6th years.

New roster structure commencing from 1st June- Core staff are on regular shifts during the week and weekends with agency staff.

PIC engaging with a small number of agencies to ensure consistency in agency staff working frontline- Complete by 7th June 2023.

PIC will be based on a full time basis in the designated center to increase level of oversight and governance, ensuring continuity of care. 22/05/2023

PIC overseeing and ensuring daily handovers are completed and all agency staff have a full induction and access to CID to document resident updates and all relevant plans and

supports. Completed by 26th May 2023.

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| Regulation 23: Governance and management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PIC will be based on a full time basis in the designated center to increase level of oversight and governance, ensuring continuity of care. 22/05/2023

PIC overseeing and ensuring daily handovers are completed and all agency staff have a full induction and access to CID to document resident updates and all relevant plans and supports. Completed by 26th May 2023.

PIC will also have daily oversight of daily audits/checklists to ensure arising actions are completed by staff, including infection prevention and control measures 08/05/2023

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| Regulation 13: General welfare and development | Not Compliant |

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
New weekly planner will be developed in consultation with residents. This will commence on Mon 22nd which will be supported fully by staff to trial and engage in community activities and linking in with day service. This will continue weekly to explore new possible goals and interests. PIC will have oversight of plans. Start date: Monday 22nd May 2023.

Weekly meetings will take place to help resident in identifying interests and support them in accessing those goals/activities if that is their will and preference- 22/05/2023.

Plan has been developed for resident who had stopped attending day service. Resident attending on a phased basis since the 17th of May, while exploring other interests at key working meetings.

Behaviour Support Specialist will meet with residents regularly beginning the week of the 28th of May 2023 to involve them in collaboratively updating their positive behaviour support plans.

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| Regulation 27: Protection against infection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
PIC has allocated separate peddle bin in bathroom for sanitary waste. PIC will ensure healthcare waste is disposed of on a regular basis. Completed by 09/06/2023

New daily cleaning sheets will be implemented with specific tasks around waste control- Completed by 02/06/2023. PIC will have daily oversight of their completion.

PIC will complete a documented weekly check that this is being conducted correctly- Completed by 26/05/2023.

PIC will discuss with all staff the importance of immediately reporting any issues identified in the daily checklist/audits going forward. This will be part of the agenda in the staff meeting- Completed by 09/06/2023.

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| Regulation 7: Positive behavioural support | Not Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Behaviour Support Specialist will meet with residents regularly beginning the week of the 28th of May 2023 to involve them in collaboratively updating their positive behaviour support plans.

Referral for counselling support for resident made by PIC the 02/06/2023.

Referral for a full psychological assessment for resident with dual mental health diagnosis sent on the 17th of May 2023 in order to have a better understanding of the resident's presentation, introduce appropriate control measures and future plan for their service. The resident will begin introduction of assessment on 08/06/2023.

Previously locally developed protocols will be removed from the designated center by the 22/05/2023.

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| Regulation 8: Protection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection: Notifications are completed and reviewed in a timely manner. Where a disclosure is made for a backdated incident, notifications are sent in as soon as the issue is raised. Notifications sent to HIQA (NOT-0778090 and NOT-0778087 ) relating to incidents that had taken place on the 11th of March had not been disclosed by residents until the 21st of March. Action taken by PIC and NF06 completed once received.

Behaviour Support Specialist will meet with residents regularly beginning the week of the 28th of May 2023 to involve them in collaboratively updating their positive behaviour support plans.

Referral for counselling support for resident made by PIC the 02/06/2023.

Mandatory Protection and Safeguarding online training will be completed by all staff members and PIC will ensure this has been completed by all staff members 09/06/2023.

## 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 13(2)(a) | The registered provider shall provide the following for residents; access to facilities for occupation and recreation. | Not Compliant | Orange | 22/05/2023 |
| Regulation 13(2)(b) | The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs. | Substantially Compliant | Yellow | 22/05/2023 |
| Regulation 13(2)(c) | The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with | Not Compliant | Orange | 22/05/2023 |

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| | their wishes. | | | |
| 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. | Not Compliant | Orange | 31/12/2023 |
| Regulation 15(3) | The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | Not Compliant | Orange | 07/06/2023 |
| Regulation 23(1)(a) | The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. | Substantially Compliant | Yellow | 31/12/2023 |
| 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 | Substantially Compliant | Yellow | 22/05/2023 |

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| | safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| 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 | 09/06/2023 |
| 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 | 28/05/2023 |
| Regulation 07(3) | The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, | Substantially Compliant | Yellow | 28/05/2023 |

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| | and are reviewed as part of the personal planning process. | | | |
| Regulation 7(5)(a) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour. | Not Compliant | Orange | 31/07/2023 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 28/05/2023 |
| Regulation 08(7) | The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. | Substantially Compliant | Yellow | 30/09/2023 |