Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Woodhill Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	03 January 2024
Centre ID:	OSV-0004944
Fieldwork ID:	MON-0042352

About the designated centre

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

Woodhill Services provides residential care and support to adults with a moderate to severe intellectual disability. The designated centre can provide residential services for up to 11 individuals from the age of 18 upwards, and can accommodate both male and female residents. The designated centre comprises of two residential houses and is located near a large urban setting. The designated centre benefits from their own transport and is located near public transport routes also. The residents have access to a range of amenities in their local community, including shops, cafes and restaurants. Some residents avail of day services outside of the designated centre and some individuals are supported to have an integrated day service within the designated centre. All residents have their own bedrooms. There is ample communal space within the centre and access to private gardens to the rear of the houses for residents to enjoy. A team of staff are on duty both day and night to support the residents who live at the designated centre, with sleepover staff in place during the night. Additionally there is an out-of-hours service to provide additional support, if required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Wednesday 3 January 2024	09:00hrs to 16:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to assess the provider's overall compliance with the regulations and to follow-up on the findings of the previous inspection carried out in March 2022. The inspection was facilitated by the services coordinator, the inspector also had the opportunity to meet with three staff members and with eight residents who lived in the centre.

The designated centre comprised of two houses, both located in residential areas near a large urban setting. One house is a large detached house and accommodates five residents in individual bedrooms with en suite shower facilities. The second house is two storey in design, it was originally built as two semi-detached houses but are now linked together internally.The second house can accommodate up to six residents in individual bedrooms some of which have en suite shower facilities. Both houses were found to be warm, suitably furnished and decorated in a homely manner. However, one of the houses was was not visibly clean, lacked evidence of routine daily cleaning which impacted upon infection, prevention and control in the house. The houses were spacious and bright with a good variety of communal spaces available for residents use. While repairs and decoration had taken place to the premises since the previous inspection further works were required to repainting of some walls. Residents had easy access to garden areas which had a variety of plants and flowers. There were paved and lawn areas with suitable outdoor furniture provided for residents use. Both houses had their own transport vehicles which could be used by residents for outing and activities.

The inspector visited one of the houses in the morning time and the other house in the afternoon and met with staff and residents in both. On the day of inspection there were nine residents being accommodated in the centre, another resident was residing on a part-time basis and there was one vacancy. Most residents availed of day services outside of the designated centre and one individual was supported with an integrated day service within the designated centre.

On the morning of the inspection, in the first house visited, some residents were up and getting ready to go to their local day services. Another resident had not yet returned to their day service as it was still closed for Christmas holidays, remained in the house and went about their own routines. They were supported by a staff member and choose to go out for the day and have lunch in the nearby city. They told the inspector how they had enjoyed Christmas and spending time with family but were looking forward to returning to day services the following week. They advised that they were happy living in the house and got on well with staff and other service users. Staff spoken with mentioned that residents had enjoyed attending many recent events including concerts, music shows and hotel breaks away. However, personal planning documentation reviewed was not up-to-date with little evidence of personal goals, review or progress as to whether goals had been achieved or not.

Staff spoken with reported that residents decided on the weekly menu for their main meals at the weekly house meetings. They advised that some residents enjoyed going food shopping and helping out in the preparation of meals. The weekly menu was displayed in written and pictorial format to remind residents what was being prepared and cooked each day. Residents continued to regularly eat out and usually enjoyed a takeaway meal of their choice on Thursdays and Sunday lunch in local hotels each week.

Throughout the morning time, residents were observed enjoying the interaction and company of staff. Staff on duty were observed speaking kindly and respectfully with residents, and responding promptly to any requests for information or support. There were no staff in the house during the day time as all residents normally attended day services during the day. While a number of staff had been recruited in recent months, the inspector had concerns that some new staff had no training and others had inadequate training in relation to fire safety management. The inspector issued an immediate action in relation to fire safety management which is discussed further in this report and under Regulation 28: Fire safety management.

Residents were supported and encouraged to maintain connections with their friends and families. There were no visiting restrictions in place. Some residents received regular visitors to the centre, while others were supported to visit family members at home. Some residents spoken with told the inspector how they had enjoyed visits and overnight stays with family over the Christmas period. Another resident told the inspector how they had enjoyed attending a family wedding. Feedback from families who had completed questionnaires at the time of the last annual review of the service, indicated satisfaction with the service provided.

During the afternoon, the inspector visited the second house and met with one staff member and residents living there. One resident was at home as they were supported with an integrated day service from the house. They were happy to show the inspector their bedroom and their family photographs which were displayed. They stated that they were happy living in the house and got on well with the other residents. They mentioned how they liked going out each day and enjoyed getting daily coffee in a local cafe. They also enjoyed listening to music and attending weekly live music sessions at a local day care service. They had recently attended a local men's shed group and were looking forward to attending again soon. The inspector also briefly met with three other residents on their return from their day service. They appeared happy, were observed to be in good form, comfortable in their environment and interacted in a friendly manner with staff. Staff were observed to support residents with hot drinks and snacks on their arrival home. The inspector noted that staff spoke kindly and respectfully with residents, and reassured residents who enquired about what staff were due on duty for the evening and night time.

While the inspector found that specific areas requiring improvement from the last inspection had been addressed, further oversight was required by the provider in relation to staffing, staff training, fire safety management, individual assessment and personal planning documentation, infection, prevention and control and the use

of some restrictive practices.

The next two sections of the report outline the findings of this inspection, in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

The governance and management arrangements in place required review to ensure effective oversight and ensure a safe and quality service for people who lived in this centre. While the findings from this inspection showed that the provider had implemented the specific areas requiring improvement as outlined in the compliance plan from the last inspection, there was much deterioration in compliance with the regulations noted on this inspection particularly in the first house visited. Improvements were required to the governance and management arrangements, staffing resources, staff training, record keeping, individual assessment and personal planning documentation, fire safety management and infection prevention and control.

The inspector was not assured that the person in charge had adequate resources to maintain effective governance, operational management and administration of the centre, given the levels of non compliance identified and as discussed throughout this report. There was a full-time person in charge who also had other managerial duties within the organisation. They were supported in their role by a services coordinator and team leader in each house. The person in charge and the team leader in one of the houses were on leave at the time of inspection. While there were an on-call arrangements in place for out-of-hours and at weekends, staff on duty in the first house visited were unaware that the person in charge was on leave and were unclear as to who was responsible for the day to day operation of the centre in the absence of the team leader and person in charge.

The findings from this inspection indicated that the centre was not adequately resourced to ensure it met the assessed needs of residents using the service. There were a number of staff vacancies including two social care workers and one support worker in the second house visited. The services coordinator advised that current vacancies were being filled by regular agency staff. The staff rota had been completed to the middle of January but many gaps had yet to be filled for the remaining weeks of January. The services coordinator advised that recruitment for these posts was on-going. Staffing levels in the first house visited required review to ensure adequate staffing resources were provided to maintain regular routine and thorough cleaning of the house.

Staff training records reviewed indicated that staff had completed most mandatory training, however, some staff had not completed fire safety training and other staff had not completed appropriate fire safety training which posed a risk to residents and staff particularly at night time. The inspector expressed their concerns and

issued an immediate action to the services coordinator who undertook to ensure that all staff were provided with appropriate fire safety training as a priority and that only staff who had completed fire safety training and who were familiar with the workings of the fire alarm system would be rostered on duty at night time.

Systems in place to monitor and review the quality and safety of care in the centre required review. While the provider had some systems in place to monitor and review the quality and safety of care in the centre including an annual review and six monthly unannounced audits, priorities and improvements identified in the annual review dated January 2023 and provider led audit dated June 2023 had still not been addressed. For example, improvements required to personal planning documentation were still not addressed. Other issues and non-compliance's identified on the day of inspection had not been recognised. The services coordinator advised that other audits including weekly safety audits were now being completed on a computerised system (FLEX), however, on review, these audits had not been completed since October 2023.

While staff spoken with advised that residents were regularly consulted with and that monthly house meetings took place, the minutes of meetings reviewed in the first house visited did not provide assurances that meaningful consultation was taking place at these meetings.

Systems in place for oversight of records required to be kept in respect of each resident required urgent review. The inspector noted poor record keeping in relation to the assessments of residents needs, personal plans and some restrictive practices in use. Fire safety checks and cleaning checks were also not consistently recorded. This is discussed further in the quality and safety section of this report.

Regulation 14: Persons in charge

The person in charge worked full-time and also had other managerial duties in the organisation. The person in charge had the required qualifications and experience for the role. However, the inspector was not assured that the person in charge had adequate resources to maintain effective oversight, operational management and administration of the centre given that they they did not have a regular presence in the centre as set out in the statement of purpose, were not included on the staff roster, and given the the levels of non compliance identified during this inspection.

Judgment: Not compliant

Regulation 15: Staffing

Staffing levels required review to ensure that the number and skill mix of staff was appropriate to the number, and assessed needs of residents, the statement of purpose and the size and layout of the designated centre.

There were a number of staff vacancies including two social care workers and one support worker. The services coordinator advised that current vacancies were being filled by regular agency staff and that recruitment for these posts was on-going.

Staffing levels required review to ensure adequate staffing resources were provided to maintain regular routine and thorough cleaning of the centre. The inspector observed that both staff on duty during the morning of inspection were very busy supporting five residents with personal care, breakfasts, administration of medications and driving them to day services. Staff did not appear to have an opportunity to complete routine cleaning during this time.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had not ensured that all staff had access to appropriate training and were appropriately supervised.

Some staff had not been provided with fire safety training and other staff had not been provided with appropriate fire safety training. Some training was provided on-line, was generic, was not centre specific and required review. There were no systems in place to review the effectiveness of training, staff spoken with were not familiar with the workings of the fire alarm system. Staff had been rostered on night duty without being provided with fire safety training. This posed a risk to residents and staff in the event of fire at night time.

Judgment: Not compliant

Regulation 21: Records

The provider did not have adequate systems in place for the maintenance and oversight of records that were required to be kept in respect of each resident. The inspector noted poor record keeping in relation to some individual assessments and personal plans. Many assessments had not been recently updated, there were no care plans in place for some identified issues, some care plans had not been recently reviewed, there were no personal goals set out for some residents and there were no progress updates or reviews completed in respect of other goals outlined. This posed an increased risk to the health and welfare of residents.

There were no records maintained in respect of some environmental restrictions in

place as set out in the providers owns policies and national policy on the use of restraint.

Records relating to fire safety checks, other safety checks and cleaning checks were not consistently recorded. The provider had systems in place for the weekly recording of safety checks, however, records shown to the inspector indicated that they had not been completed since October 2023. There were daily cleaning checklists in place, but records reviewed showed that they had not been completed since 11 December 2023.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place did not ensure that the service provided was safe, appropriate to the residents needs, consistent and effectively monitored. The findings from this inspection indicated that the provider had failed to adequately resource this centre, to ensure it met the assessed needs of residents using the service. The provider was in breach of the majority of regulations reviewed.

The inspector was not assured that the person in charge had adequate resources to maintain effective oversight, operational management and administration of the centre given that they they did not have a regular presence in the centre as set out in the statement of purpose, were not included on the staff roster, and given the the levels of non compliance identified during this inspection.

Some staff had not been provided with fire safety training and other staff had not been provided with appropriate fire safety training. Staff spoken with were not familiar with the workings of the fire alarm system. Staff had been rostered on night duty without being provided with fire safety training. This posed a risk to residents and staff in the event of fire at night time. The inspector expressed their concerns and issued an urgent action to the services coordinator who undertook to ensure that all staff were provided with appropriate fire safety training as a priority and that only staff who had completed fire safety training and who were familiar with the workings of the fire alarm system would be rostered on duty at night time.

Staffing levels required review to ensure that the number and skill mix of staff was appropriate to the number, and assessed needs of residents, the statement of purpose and the size and layout of the designated centre. There were a number of staff vacancies including two social care workers and one support worker. Staffing levels required review to ensure adequate staffing resources were provided to maintain regular routine and thorough cleaning of the centre.

Systems in place to monitor and review the quality and safety of care in the centre required review. The provider had identified priorities and improvements required to personal planning documentation as an outcome of the annual review dated January 2023 and provider led audit dated June 2023 but these improvements had still not

been addressed. Other issues and non-compliance's identified on the day of inspection had not been recognised by the audit systems in place. Further oversight was required to the fire safety management, infection, prevention and control and restrictive practice.

There was inadequate oversight of records required to be kept in the centre. Weekly safety audits and other fire safety checks had not been completed since October 2023. Daily cleaning checklists had not been completed since 11 December 2023. There were no records maintained in respect of some environmental restrictions in place as set out in the providers owns policies and national policy on the use of restraint.

Judgment: Not compliant

Quality and safety

The staff on duty and residents spoken with on the day of inspection provided assurances that residents received an individualised service and that their health and welfare was promoted. Residents who the inspector met with stated that they enjoyed living at the centre, appeared to be comfortable in their environment and with staff supporting them. However, as discussed under the capacity and capability section of this report, improvements required to the governance and management arrangements, staffing resources, staff training, record keeping, individual assessment and personal planning documentation, fire safety management and infection prevention and control impacted upon the quality of life and safety of residents.

The inspector reviewed a sample of residents files and noted many inconsistencies in the records reviewed. There were no care plans in place for some residents' specific health care conditions and other care plans in place had not been regularly or recently reviewed. Personal outcomes or goals were not set out for all residents and where goals had been set out, there was not always evidence of progress or evidence as to whether the goals had been achieved or not.

Residents had timely access to General Practitioners (GPs), out of hours GP service, consultants and a range of allied health services. Files reviewed showed that residents had an annual medical review. Each resident had a hospital passport which included important and useful information specific to each resident in the event of they requiring hospital admission, however, some had not been reviewed since March 2022.

Further oversight was required by the provider to ensure that residents were protected from the risk of infection. Parts of the centre as well as cleaning equipment were found to be visibly dirty and showed obvious lack of regular and routine cleaning. The storage of boxes of incontinence products and hygiene products on the floor as well as improvements required to the repair and

maintenance of the physical environment further hindered effective cleaning of the centre.

The arrangements in place for the management and oversight of fire safety and fire safety training required review. All staff had not completed fire safety training while training provided to other staff was not appropriate. Fire safety checks had not been consistently recorded and all staff had not completed or been involved in a fire drill.

The provider had not ensured that all environmental restraints in use were applied in line with national policy. While there was evidence of regular review of all restrictive practices in use in one of the house visited, including evidence of less restrictive practices being trialled and others being considered. The inspector noted that there were no records maintained for some environmental restrictions in use in the other house.

Regulation 27: Protection against infection

Further oversight was required by the provider to ensure that residents were protected from infection by adapting procedures consistent with the National Standards for infection prevention and control in community services.

- Parts of the centre were found to be visibly dirty and showed obvious lack of regular and routine cleaning.
- Areas including bathrooms, shower trays, shower equipment, toilets, wardrobes, floors, areas behind doors, ledges and holders for displaying information were found to be visibly dirty.
- Cleaning equipment including sweeping brushes were visibly dirty.
- Daily cleaning checklists displayed had not been completed since 11 December 23.
- There were no hand drying facilities provided to a shared bathroom for staff or residents.
- There were cardboard boxes of incontinence products, hand hygiene supplies including rolls of paper hand towels stored on the floor contrary to good infection control practice and preventing the thorough cleaning of floors.
- There were large quantities of face masks stored in open boxes in the laundry room/utility room area.
- Rolls of clinical waste refuse bags were also stored on the hall table.
- Other improvements were required to the repair and maintenance of the physical environment to ensure surfaces were conducive to effective cleaning and to enhance infection control. For example, there was a torn and defective dining chair, some walls required repainting due to staining and flaking paint.

Judgment: Not compliant

Regulation 28: Fire precautions

The arrangements in place for the management and oversight of fire safety and fire safety training required review. Some staff had not been provided with fire safety training and other staff had not been provided with appropriate fire safety training. Some training was provided on-line, was generic, was not centre specific and required review. Staff spoken with were not familiar with the workings of the fire alarm system. Staff had been rostered on night duty without being provided with fire safety training which posed a risk to residents and staff in the event of fire at night time. Fire safety checks had not been consistently recorded. Daily fire safety checks were no longer being recorded and weekly safety audits which included fire safety checks had not been completed since October 2023. A review of fire drill records showed that while drills had been completed, not all staff had completed or been involved in a fire drill. Records reviewed in one house visited showed that only one staff member had been involved in a night time scenario fire drill during 2023.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were no care plans in place for some residents specific health care conditions. Some care plans in place had not been reviewed since February 2022. Another file reviewed indicated that the last progress review meeting for the resident took place in January 2022, therefore, the inspector was not assured that these care plans reflected the up-to-date support needs of residents. There were no personal goals outlined for 2023 for a resident in the documentation reviewed. While personal goals were outlined for other residents, there was not always evidence of progress or review meetings held to discuss progress or effectiveness of the plans. The names of those responsible for pursuing objectives in the plan within agreed timescales were not always identified or recorded. There was not always evidence as to whether the goals set out in the plan had been achieved or not. The provider had identified that improvements were required to personal planning documentation in January 2023 and in June 2023 but these improvements had still not been addressed.

Judgment: Not compliant

Regulation 6: Health care

Staff continued to ensure that residents had access to the health-care that they needed. Residents' with specific medical conditions continued to be closely monitored. Residents had regular and timely access to general practitioners (GPs)

and health and social care professionals. A review of a sample of residents files indicated that residents had been reviewed by the physiotherapist, occupational therapist (OT), psychologist, chiropodist, optician and dentist. Residents had also been supported to avail of the national health screening and vaccination programmes.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had not ensured that all environmental restraints in use were applied in line with national policy. There were no records maintained for some environmental restrictions in use. There was no clear rationale outlined for its use, no records of its use and no risk assessment completed for its use.

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 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Woodhill Services OSV-0004944

Inspection ID: MON-0042352

Date of inspection: 03/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: To provide assurances that the person in charge (PIC) can maintain effective oversight, operational management and administration of the centre and provide a regular presence in the centre as set out in the statement of purpose, the person in charge has reduced PIC responsibility from four designated centres to responsibility of two designated centres. The reduction in PIC responsibility of designated centres has facilitated an increase in the routine and regular weekly time presence of the Person in Charge in the Woodhill Services. This has facilitated an increase in time allocated to maintaining effective oversight, and monitoring of the operational management and administration of Woodhill Services to ensure compliance with the regulation 14.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A fulltime support worker commenced on 16 January 2024 filling one of three vacancies in the Designated Centre. Ongoing bespoke recruitment campaigns will continue to target recruitment for the service area. A third recruitment campaign for skilled two Social Care Workers has commenced. The campaign, aiming to attract skilled applicants, will target the use of social media, radio, print media and local flyers, similar to recruitment campaigns held in 2023. The risk assessment of vacant staffing posts is reviewed and updated regularly. The staffing risk assessment has been consistently escalated (2 October '23, 12 October '23, 12 December '23 and 25 January '23), in line with the organisation's risk management	

policy, to the provider and the HSE to reflect ongoing challenges in attracting skilled staff to the service area. Derogation is being sought from the HSE for the filling of vacant posts. The derogation forms will submitted to the HSE on 28/2/2024. All vacant posts will be re-advertised.

Regular and consistent agency staff are engaged to cover the two remaining vacancies in the designated centre.

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Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training requirements of all staff have been reviewed and an action plan completed. In house fire training was completed by all staff on 29/1/24. All staff will complete mandatory trainings by the 1st of April 2024.
The Team leader will complete the following trainings:
- Risk management on 12/2/24
- Code of practice on 13/2/24
- Personal outcomes and Key worker on 20&21 /2/24
- Daily living skills on 6/3/24

To promote staff development and encourage best practice, staff will complete Code of Practice, Personal Outcomes and Key Worker, and Daily Living Skills trainings within six months. The Service Co-ordinator, in association with the Team Leader, will monitor completion of staff training.

Effective from February 2024, the Team leader will provide formal quarterly support and supervision for staff and provide informal and peer to peer supports through nine scheduled team meetings per year.

Effective from February 2024, the Team leader will provide formal quarterly support and supervision for staff and provide informal and peer to peer supports through nine scheduled team meetings per year.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Person in Charge has enhanced the scheduled oversight of records in respect of people supported in the residence. On 16/01/2024 the Person in Charge oversaw the allocation of new Key Workers to each person supported, and ensured enhanced awareness of the team in the role of the key worker in record keeping and report writing with specific focus on updating, reviewing and completing Personal Profiles and individual Personal Outcomes Measures (POMs) by 31/05/2024.

On 16/01/2024, the Person in Charge reviewed best practices in relation to reporting and record keeping and the maintenance of Personal Profiles with team members. The Person in Charge, in association with the Quality & Training Department (QED), coordinated two bespoke workshops for team members focusing on maintaining person-centered planning, Personal Profiles and Personal Outcome Measures (POMS) in one house on 31/01/24 and 07/02/24.

Effective from January 2024, the Person in Charge will provide monthly scheduled supervision sessions with the Team Leader in the designated centre to review, ensure compliance with and address issues in relation to the management of person centred records, personal profiles, care plans and personal outcome plans.

Effective from 17/01/2024, the Person in Charge monitors and reviews the online Safety Checklist and the Infection, Prevention and Control (IPC) Checklist on a monthly basis at team leaders meetings, and will review the Checklists onsite with the Team Leader on a monthly basis to ensure the accurate recording of information.

The Person in Charge scheduled a review of care plans by the Clinical Nurse Specialist, completed on 07.02.2024, subsequently collated information and recommendations following the review. The Person in Charge will review and oversee the implementation of recommendations and update of care plans to mitigate against any potential risk to the health and welfare of the people supported on a monthly basis, until all care plans are updated by 31/05/2024. A CNM1 with clinical experience has been delegated responsibility for the additional fortnightly oversight of the updating of care plans. The Person in Charge will review care plans with the Team Leader every month for six months to assure compliance with regulation 21.

The minutes of scheduled MDT meetings will be discussed at the team meetings to ensure that assessed needs of people supported are reviewed and person centered planning updated to ensure the quality and safety of services meets the assessed needs of the people supported.

Regulation 23: Governance and management	Not Compliant

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

management:
To ensure compliance with Regulation 23, the Person in Charge will maintain a weekly presence in the Designated Centre, or more frequently as required. As outlined in the statement of purpose, the weekly presence of the Person in Charge in the designated Centre will be enhanced by the support and presence of the service coordinator and team leader in the designated centre to strengthen the effective oversight, monitoring, governance and management of the Designed Centre

The Person in Charge has overseen the provision of fire safety training of all staff in the designated centre. An urgent action issued on the day of inspection was completed by the service coordinator on 29/01/2024, and staff were provided with appropriate face to face in house fire safety training as a priority. The Person in Charge has ensured that only staff who had completed fire safety training, and who are familiar with the workings of the fire alarm system, are rostered on duty at night time.

Staffing levels were reviewed to ensure that the number and skill mix of staff was appropriate to the number and assessed needs of people supported, the statement of purpose and the size and layout of the designated centre. The housekeeper hours have increased by 33% to 15 hours per week to maintain regular routine and thorough deep cleaning of the centre. A fulltime support worker commenced on 16 January 2024. The Person in Charge ensures that regular and consistent agency staff are engaged to cover the two remaining vacancies in the designated centre. The Person in Charge continues to engage with HR to recruit two skilled Social Care Workers to provide a regular fixed roster that supports oversight and review of the quality and safety of care within the designated centre.

Through training and delegation of tasks to staff, the Person in Charge will ensure that the identified priorities and improvements required to personal planning documentation, and oversight of fire safety management, infection, prevention and control and restrictive practices will be implemented as scheduled and documented on the relevant online platforms to improve the monitoring and review of the quality and safety of care in the centre.

The Person in Charge has ensured:
• A review of restrictive practice protocols was completed by the Advanced Nurse Practitioner(ANP) in Behaviours of Concern on 29/01/2024 in line with the providers and national policy on the use of restraint. Referral of restrictive practices to the Human Rights Committee was completed on 07/02/2024.
• Staff members will complete HSELand HIQA Applying Human Rights-Based Approach Modules 1 to 4 to ensure that staff recognise and understand restrictive practices and continuously work towards reducing restrictions. Training will be completed by 31/07/2024.
• The Person in Charge will continue to review all Accident and Incident Reports on quaterly basis to monitor the behavoiurs associated with the restrictive practices and to inform improvements in practice through discussions at Team Meetings.
• Scheduled regular MDT Team meetings with the staff team will review restrictive practices, and collaboratively work towards a restricitve free environment.
• Fire Safety Training has been completed. The Person in Charge will ensure that all new staff complete face to face fire safety training and complete a fire drill prior to working

on night duty.
• The Infection Prevention and Control (IPC) Link Practioner has completed an IPC audit and submitted recommendations to the Person in Charge. The Person in Charge, in collaboration with the Team Leader, will ensure that actions are completed by 31/05/2024.
• The Person in Charge and Team Leader will provide ongoing support for staff to ensure the recurring maintenance and update of individual records, care plans and POMs plans.
• The Team Leader is rostered to work across shifts to strengthen governance, and consistently provide support, practice leadership, mentoring and guidance for frontline staff.
The Person in Charge will continue to review all Accident and Incident Reports on a quarterly basis in line with submission of HIQA Quarterly notifications as currently implemented.
The Person in Charge arramged that the Social Work Department will develop a team training to focus on strengthening a culture of shared learning and improvement through discussion at team meetings, review of practices, safeguarding, incidents, fire safety, risk management and restricitve practices and the provision of support and training for staff. The open discussion will lead to further learning driving change for improvement in the designated centre. Training will be completed 31/05/2024.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Person in Charge coordinated an Infection Prevention and Control (IPC) Audit which was completed by an IPC Link Practitioner on 20/01/2024. Actions were identified. The Person in Charge will oversee the implementation of the actions and recommendations identified through the audit. Effective from 17/01/2024, the Person in Charge will monitor and review the IPC Checklist on a monthly basis, onsite with the Team Leader to ensure compliance with the Organisation's and the National Standards for infection prevention and control in community services.

Funding has been agreed for the completion of identified remediation works. The works have commenced and Person in Charge will ensure the completion of maintenance, renovation and decorating works by 30/06/2024. A deep clean of one house in the Designated Centre was completed on 05/01/2024. Internal building works have been completed and building dust removed. Housekeeping hours allocated to the house have increased from 10 to 15 hours per week.

On 16/01/2024 the Person in Charge discussed with the team the actions required to comply with Regulation 27 - all cleaning tasks and IPC measures undertaken by the team will be based on the guidance provided by the Organisations's Infection, Prevention and Control Cleaning Guidance Manual and the National Standards for IPC in Community

Services. The Person in Charge and service coordinator updated the daily and weekly cleaning recording chart(s) on the 26/01/2024 and issued the new checklists to the team. Staff were informed of their shared responsibility to prevent and control infection in the designated centre and the Team Leader was delegated responsibility to ensure that staff rostered were aware of their role in cleaning in the absence of housekeeping staff. The Person in Charge will ensure a regular and routine weekly presence in the designated Centre to monitor compliance with regulation 27 - protection against infection

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
On the day of inspection, the Service Co-ordinator reviewed the use of the fire panel with staff. The Person in Charge ensured that the Fire Panel Instructions were rehung on the wall beside the fire panel on 30/01/2024.

The Person in Charge scheduled onsite face to face training with Ignite Fire and Safety Training Ltd. for all staff members in the house. Face to face fire training was completed by all staff members on 29/01/2024 including instruction on local in house evacuation procedures, uses of the panel and firefighting. A fire drill was completed in the house under the supervision of the Fire Safety Officer, evacuation was completed in 2.20 minutes and no corrective actions identified. Staff have, subsequently, completed two fire drill in the house. The Person in Charge will ensure that all staff take part in at least one fire drill a year and that a minimum of three fire drills will be completed and recorded each year as per the organisation guidance. When corrective actions are identified more frequent fire drills will be scheduled.

The Person in Charge will monitor the weekly and monthly fire and safety control checks on the online system on a monthly basis in order to ensure and monitor compliance

Fire and Health & Safety are an agenda item at scheduled team meetings.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
An audit of care plans was completed by the CNS 07/02/2024 and any required improvements were discussed with the Team Leader. All necessary care plans for the assessed needs of each person supported will be in place as Personal Profiles are being

reviewed and updated. The Person in Charge has given the responsibility to the service coordinator to support a CNM1 and Team Leader to review and update all care plans. This will be completed for all persons supported in the house before 31/05/2024 and will benefit from the oversight and guidance of the CNS.

Key workers have been assigned to each person supported and individual POMs Plans are currently being reviewed and updated. A meeting to review hopes and dreams for 2024 with each individual will be completed before 31/04/2024 and an action plan on how best to support people to achieve their hopes and dreams will be agreed. The implementation and review of personal plans will be reviewed on a quarterly basis by the PIC as part of the quarterly audit.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge referred the use of the restrictive practice to the Advanced Nurse Practitioner (ANP) in behaviours of concern. The Positive Behaviour Support Plan for the individual, and recording of accidents and incidents in relation to the restrictive practices, was reviewed by the ANP on 29/01/2024. The revised protocol will provide clearer guidance on the monitoring of behaviours associated with the restrictions on the accident and incident reporting system (AIRS). The Person in Charge will attend MDT meetings scheduled throughout the year to oversee the review of restrictive practices, positive behavior support plans and monitor progress in working towards a restriction free environment, and ensure regular discussion at Team Meetings.

Restrictive Practice was forwarded to the Human Rights Committee for review on 02/02/24.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	12/02/2024
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	12/07/2024
Regulation	The person in	Not Compliant		01/04/2024

16(1)(a)	charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.		Orange	
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/05/2024
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.	Not Compliant	Orange	12/07/2024
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.	Not Compliant	Orange	31/05/2024
Regulation 27	The registered	Not Compliant	Orange	31/05/2024

	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.			
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	29/01/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably	Not Compliant	Orange	29/01/2024

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	31/05/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/05/2024
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the	Not Compliant	Orange	31/05/2024

	supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/05/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	07/02/2024