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:	Beaufort Campus Units Area 2 - St. John of God Kerry Services
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	07 November 2019
Centre ID:	OSV-0002905
Fieldwork ID:	MON-0027954

About the designated centre

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

The service was based on a large campus in proximity to a rural village.The service provided residential care for up to 43 residents who had moderate or severe intellectual disability. Some residents had a dual diagnosis and significant medical conditions. Residents were male and female and five of the residents availed of shared care and respite. Many of the residents had lived in the designated centre since they were young children. Accommodation was in 10 separate houses or units / apartments. Three residents had individual apartments. Between two and eight residents resided in each house. All accommodation was at ground floor level. The campus grounds were generally well maintained. The service was nurse led and the staff team comprised of nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 November 2019	14:30hrs to 19:30hrs	Michael O'Sullivan	Lead
Thursday 7 November 2019	14:30hrs to 19:30hrs	Niall Whelton	Lead
Thursday 7 November 2019	14:30hrs to 19:30hrs	Lucia Power	Support

What residents told us and what inspectors observed

The inspectors met with 22 residents on the day of inspection. Many residents had complex care needs and significant communication difficulties. Some residents from all premises were off site attending day services and day programmes or were involved in external activities during the course of the inspection.

The inspectors observed meaningful interactions between residents and staff. Staffs focus was more person centred and all premises had current activity boards which reflected the planned activities that residents were engaged in. The current menu and food choices for the day of inspection were reflected accurately on all notice boards, however the notices in one residents apartment were three days old.

It was evident that staff had a very good understanding of residents needs and it was apparent from staff that were spoken to that advocacy on behalf of residents needs was to the forefront of what they did. Residents appeared to be happy with the support of staff and this was evident through gestures and sound. The inspectors noted the engagement between staff and residents to be warm and considerate.

Capacity and capability

This was a follow up inspection to determine the level of compliance with the previous inspection of May 2019 and the registered providers compliance plan to address regulatory breaches.

A number of improvements were noted by the inspectors since the previous inspection. Overall the provider had taken some measures to address staff shortages that included the recruitment of additional staff, as well as a review of all staff within the designated centre for the purposes of best matching staff and skill mix to the assessed needs of the residents. A comprehensive action plan to bring the designated centre into regulatory compliance was actioned and reviewed monthly through all levels of management.

The current staff rosters reviewed on the day of inspection reflected less movement of staff between designated centres on the campus. The registered provider had made representation and business cases for additional staffing with the recruitment of one staff member since the last inspection. The roster did however reflect a continued reliance on relief staff which involved the regular movement of staff between some of the premises. This premises that provided a service for five residents had minimum staffing levels of two to three staff members allocated and a

dependence on relief staff from other premises. Staff rosters also recorded that nurses on leave from night duty were replaced by social care workers. Residents activation and access to the wider community remained subject to and limited by staff availability and numbers. There was evidence in some units of activity cancellations as a result of staff shortages in the campus based day service. The cancellation of residents attending the day service was predicated and prioritised on when the resident was last in attendance, how many times the resident had previously been cancelled and the risk to other residents if a residents behaviour escalated due to non attendance.

The provider had put in place an accelerated training schedule to make sure all staff were trained in the areas of fire and safety, managing behaviours that challenge and safeguarding vulnerable adults. Staff yet to complete refresher training had allocated training dates for 2019 / 2020.

Governance and management improvements were observed and readily identifiable through staff meeting records and information sharing as well as local managements involvement, implementing change and improvements in each premises. There was documentary evidence demonstrating meetings and representations locally and nationally within the organisation as well as externally with the Health Services Executive (HSE). These meetings and documents outlined areas of performance management, resources, finances and regulatory compliance with identified concerns being escalated locally through sub committees to the executive committees and the national board of the organisation. The organisation had also applied additional focus to staff training in relation to transforming lives. The registered provider had made improvements to the management systems in place in the designated centre; however, the provision of services appropriate to residents assessed needs required continued oversight to ensure actions and follow up were advanced. Consultation with residents and families in relation to the annual review of the quality and safety of the service provided to residents was limited to family questionnaires. The registered providers quality and safety lead was reviewing the designated centres composition and residents' needs as well as rolling out additional training to staff in relation to supported self directed living. Despite improvements, planned works for premises, fire and safety and the lack of community access for residents remained in breach of the regulations.

The systems of governance and management in relation to fire safety required improvement to ensure that the service provided was safe. While inspectors noted many examples of good practice in relation to fire precautions and there was a programme of fire safety works in place, the inspector was not assured that the fire safety arrangements in place were fully adequate to ensure the safety of residents as outlined in Regulation 23 and Regulation 28 of this report.

This inspection included review by a specialist inspector in Estates and Fire Safety from the Chief Inspector’s office. At the last inspection on the 13 August 2019, concerns were raised regarding fire doors and effective evacuation of residents. On foot of the findings at the last inspection, the Chief inspector requested the provider to arrange and submit a fire safety risk assessment for the designated centre.

In response to the fire safety risk assessment of the centre, the provider's architect prepared a schedule of fire safety works, which included upgrade and replacement of fire rated doorsets, provision of appropriate door closing devices and fire sealing of recessed light fittings in ceilings.

At this inspection, fire precautions was assessed with a particular focus on the progress made on fire safety works identified at previous inspections, fire safety management practices in place, including the physical fire safety features in the building and the outcome of the fire safety risk assessments. Inspectors spoke with and reviewed the buildings in the presence of the facilities manager, the health and safety coordinator and architects retained by the registered provider. Inspectors were shown a schedule of proposed works to be completed by March 2020 to address all previously identified fire works.

Inspectors noted that fire safety registers were well laid out, accessible and kept up-to-date. The provider had made the necessary arrangements for fire safety training to be provided to staff. Inspectors spoke with staff who were knowledgeable of the evacuation procedures to be followed and of their role.

The person in charge had updated the statement of purpose to include all required information and the statement was available to residents. The directory of residents was current and all required information was up to date.

Regulation 15: Staffing

The registered provider did not ensure that the number, qualifications and skill mix of staff was appropriate to the numbers and assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training. However, some staff had yet to undertake training that they were booked on.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents in

the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had made improvements to the management systems in place in the designated centre, however, the provision of services appropriate to residents assessed needs required additional oversight and actions to advance. Service user involvement in the annual review process was limited to family questionnaires.

The systems of governance and management in relation to fire safety required review and improvement to ensure that the service provided was safe. While inspectors noted many examples of good practice in relation to fire precautions and there was a programme of fire safety works in place, the inspector was not assured that the fire safety arrangements in place were fully adequate to ensure the safety of residents in the event of a fire. This was evident in the following:

- the locking mechanisms to some bedrooms were found to create a potential risk to the safety of residents
- the processes for identification and management of fire safety risk was not adequate.
- oxygen cylinders were observed in locations where they could be damaged by a doors swing and within rooms containing combustible materials
- storage enclosures along escape corridors were not adequately enclosed in fire rated construction.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place which contained all necessary Schedule 1 information.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a complaints procedure in place that clearly

demonstrated that complaints were appropriately responded to and outlined the appeals process.

Judgment: Compliant

Quality and safety

The inspectors noted that there was some improvement in the quality and safety of services to residents since the last inspection. Some premises had been decorated and remedial works and renovations were nearing a state of completion.The registered provider demonstrated a commitment to addressing deficits and improvement was noted in relation to residents' rights and the application and review of restrictive practices. Residents' rights however remained impacted by staff resources and how staff were allocated. While the registered provider had taken actions to address many of the issues pertaining to fire and safety, planned works to address fire door issues relating to door closure devices remained outstanding.

From a fire safety perspective, the main issue of concern to inspectors were that;

The doors to some bedrooms in one unit had inappropriate locks fitted to the corridor side of the doors. While this was a measure put in place for the protection of resident's property, inspectors were concerned that adequate controls were not in place to ensure staff could quickly access the bedroom to assist the resident to evacuate. One instance included a loose key in the lock on the corridor side of the door, which could easily be misplaced and the others required a specific code to be entered manually to gain access to the room, with no fail safe mechanism to release the lock if the fire alarm was activated. This was brought to the attention of the person in charge.

Inspectors found that precautions against the risk of fire required improvement, for example, the arrangements for the storage of oxygen cylinders at the centre required review. A risk assessment for the storage of oxygen was not available when requested.

In general the building was laid out in a manner that provided an adequate number of escape routes and fire exits.

The inspectors noted that each building was provided with emergency lighting, fire fighting equipment and a fire detection and alarm system. The fire safety risk assessment for the designated centre identified that the system for summoning staff to assist in evacuation was cumbersome and recommendations included a paging type device to be installed as a matter of urgency. It was explained to inspectors by the health and safety coordinator, that a system has been finalised and was on order. This was due to be implemented within a few weeks of the inspection date. The proposed system includes an application installed on mobile phones, customisable to ensure any fire alarm activation would be notified to staff in each

unit.

The fire detection and alarm system provided within the designated centre met the required L1 standard. Adequate emergency lighting was provided throughout the designated centre, enhancing the means of escape in the event of a fire.

Documentation furnished to inspectors showed that the fire detection and alarm system and the emergency lighting system throughout were serviced at the appropriate intervals.

In the main, each building was subdivided with construction that would prevent the spread of fire and smoke through each building. However, there were fire doors which were identified as requiring replacement, sealing was required to complete fire barriers in some instances where building services penetrated fire rated construction. A significant number of fire doors were not fitted with automatic closing devices, but there was a plan in place to address this.

Each resident had a Personal Emergency Evacuation Plan (PEEP). These were sufficiently detailed. The person in charge had introduced an easy to read format based on residents assessed needs.

Inspectors reviewed documentation in terms of regular in house fire safety checks in the centre and while there were some minor omissions in these checks, they were noted to be completed. However, there was no record of regular checks of fire doors in terms of maintenance requirements.

A number of residents bedrooms had doors that were combination lock controlled. One other residents' bedroom was locked with a key and the key left in situ. Some of these controls were subject to interference by other residents. Inspectors were of the view that while these control measures were in place to protect residents personal possession, they were not properly risk assessed regarding resident safety and the risk that may occur in the event of a fire and the safe evacuation of residents.

The premises were observed to be better maintained and one premises that had required decoration and upgrading was near completion. Premises were cleaned to a good standard. Inspectors also noted that a visitors room that linked two premises had reverted to it primary function as a room for visitors. New and additional furnishings had been secured since the last inspection and the area had been redecorated.

Residents' files were stored securely in cupboards that had been provided since the last inspection. Some resident information and files were on display between a kitchen and staff office area within one premises. Staff informed inspectors that a cupboard was awaited.

The person in charge ensured that each staff member had the necessary knowledge and skills to respond to behaviours that challenge and to support residents manage their behaviour. Additional external resources had been sourced and provided on

campus to assist staff and residents since the last inspection.

A sample of residents' individual care plans were reviewed by the inspectors. It was evident that the plans that were reviewed were up-to-date. Resident goals had been achieved. The individual care plans were provided to residents in an easy-to-read format and staff had evidence of progress in this area which involved the use of residents electronic tablets. There was also good evidence of health care plans and follow up in relation to residents. All health related issues had a specific health care plan. There was good evidence of positive behavioural support for residents requiring this support, records were clear and it was evident there was ongoing review and tracking of information. This was clearly evident in the training of staff and the prioritisation of resident referrals to an external contractor.

The registered provider had undertaken an extensive review of residents' rights since the last inspection. Each resident had in place a rights awareness checklist and all documentation and referrals to the providers human rights committee had also been reviewed. This report recorded additional community activities, the referral of some restrictive practices and the closure of others by the human rights committee. It was evident that all residents had unrestricted access to toilet areas and toiletries, had sufficient and proper storage space within their living areas and bedrooms, as well as laundry baskets to promote person centred care. Locks on some garden gates had been removed after a risk assessment and staff were committed to the ongoing review of restrictive practices.

There was evidence of residents accessing the community and the registered provider had acquired an additional minibus, however recreation and occupational activities remained limited. Staff were compiling accurate information regarding resident's activity timetables, meaningful day planners, access to skills training and activity logs. Records also included photographs of residents engaged in activities.The greater proportion of activities for residents remained house or campus based. Activity schedules indicated greater staff involvement in planning and recording activities as well as the reasons for non fulfilment when activities were cancelled due to staff shortages. Inspectors were of the view that while improvement had occurred, residents were not able to access facilities for recreation in accordance with their wishes and interests. Many residents activities were confined to the campus.

Regulation 11: Visits

The person in charge ensured that a suitable and private place was available to receive visitors in the designated centre.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge ensured that each resident had access to and control over their personal property, where reasonably practical.

Judgment: Compliant

Regulation 13: General welfare and development

While the registered provider had made improvements to ensure residents access to facilities for occupation and recreation in line with residents interests, capacities and developmental needs, the necessary staff supports to develop and maintain these links required further resources.

Judgment: Not compliant

Regulation 17: Premises

The design and lay out of the designated centre did not meet the needs of residents who continued to share bedrooms. The extension of two premises was awaited.

Judgment: Not compliant

Regulation 26: Risk management procedures

Some risk control measures were not proportional to the risk identified and adverse impacts on residents were not considered. For example, the locking of residents' bedroom doors required thorough risk assessment.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety management systems in the designated centre required improvement to ensure the safety of residents.

The inspector was not assured that adequate precautions were being taken against the risk of fire in the following respects:

- The arrangements for the storage of oxygen cylinders required review. Some were observed to be located in the path of a doors swing, potentially causing damage to the cylinder concerned. They were located with rooms containing combustible material. When requested, risk assessments for the use and storage of oxygen cylinders were not available.

The inspector was not assured that adequate means of escape was provided, for example;

- The doors to some bedrooms in one unit had inappropriate locks fitted to the corridor side of the doors

Adequate arrangements had not been made for containing fires;

- Inspectors observed penetrations for light fittings through the fire rated ceilings in some units.
- Inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery). While there was a programme of works for the replacement of identified deficient fire doors, some doors along escape routes were observed that were not fitted with cold smoke seals which would be expected to be replaced/fitted in the interim. Fire doors to bedrooms were not fitted with devices which would close the door when the fire alarm system is activated. In the main, staff spoken with confirmed that fire doors were required to be kept closed.
- Some storage presses along escape corridors were not adequately enclosed in fire rated construction.
- Some fire stopping was required where building services penetrated fire resisting construction.

Inspectors were not assured that adequate arrangements had been made for evacuating all persons from parts of the centre in a timely manner:

- In one unit, drill records indicated an evacuation time in excess of five minutes to evacuate the unit. This evacuation time is considered excessive and the registered provider should strive to reduce this time to ensure the safety of residents. Furthermore, this drill included the evacuation of a resident using a ski-sheet, which required two staff members to assist the resident. On this occasion, the drill record showed a time in excess of two minutes and forty seconds for the second staff member to arrive at the unit to assist in the evacuation. Inspectors were not assured that one staff member was sufficient if the fire started in the room where the resident requiring two staff members was accommodated. This drill record also identified the requirement for further training in the use of the evacuation sheet.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each resident had an individual care plan that was subject to assessment and effectiveness and reflected changes in circumstance.

Judgment: Compliant

Regulation 6: Health care

The registered provider had in place appropriate healthcare for each resident.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge ensured that each staff member had the necessary knowledge and skills to respond to behaviours that challenge and to support residents manage their behaviour.

Judgment: Compliant

Regulation 9: Residents' rights

While some improvements were noted since the last inspection, residents personal and living space as well as freedom to exercise choice and control of their daily life remained limited.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Beaufort Campus Units Area 2 - St. John of God Kerry Services OSV-0002905

Inspection ID: MON-0027954

Date of inspection: 07/11/2019

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 Registered Provider is engaged with the Statutory Funding Agency to address the legacy issues relating to staffing levels within the congregated setting and has submitted comprehensive proposals on Funding required to the statutory authority. The Registered Provider has submitted an updated proposal to the Statutory Funding Agency for additional staffing to ensure the numbers of staff are appropriate to the assessed needs of residents and is in ongoing communication to progress same. Proposal submitted on 13/08/19.

• A business case has been submitted to the HSE with a request to fund an increase in staffing to aid with the residents preferred community activities. The HSE have advised that they will fund an increase in staffing to develop a community integration programme to support residents on campus (3 posts).
Completed 31/12/2019

• The above posts will be advertised in Feb 2020 and subsequently interviews will take place with a planned start date for these three additional posts scheduled for June 2020 pending successful recruitment campaign.
Completion Date: 30/06/2020

• The registered provider in consultation with the PIC has reviewed and committed to re-assigning the current available skill mix across locations i.e. nursing/social care and care staff based on residents needs. Due to commence in Feb 2020.
Completion Date: 30/03/2020

• The registered provider is implementing an ongoing recruitment strategy to fill existing vacancies within the Designated Centre, which will be in keeping with the revised skill mix allocation. Completion date:30/03/2020

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The PIC in conjunction with the CNM2 manager will review the training log and calendar on a monthly basis in order to identify staff that are due to complete refresher training thus scheduling them to attend at the next available date.
In doing so the PIC will identify any staff members who require refresher training particularly in the following areas: fire and safety, managing behaviours that challenge and Safeguarding and will schedule these individuals as required.
Completion date: 30/06/2020

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
23(1)(a)
• The Registered Provider is implementing an ongoing recruitment strategy to fill existing vacancies within the Designated Centre.
Completion Date:30/03/2020

• The Registered Provider has reviewed the existing practice of cross Designated Centre cover onsite and limits this practice to unforeseen absences within the Designated Centre. A protocol has been finalised and same is being implemented in conjunction with the PIC and allocations officer across each location within the DC.
Completion Date:30/03/2020

• The Registered Provider, in consultation with the PIC, has reviewed the existing governance structure within the Chalets. This review assessed the current use of frontline staff and recommendations highlighted are due to be implemented in the February 2020 roster in order to ensure frontline resources are based on residents needs and the current WTE; and same is allocated to the maximum benefit of all residents.
Completion date: 30/03/2020

23(1)(c)

• In relation to the resident identified in the report with a loose key on their bedroom door a break glass system was installed and trialed however this was not tolerated by the resident due to their individual needs. Completed 21/11/2019

• The following additional control measures have been put in place in this location, an additional key is located on a hook beside the resident's door which is being tolerated and left in place by the resident. Completed 22/11/2019

• All staff members have a key to the resident's bedroom on their person for the duration of their shift. Completed 30/11/2019

• The registered provider has installed a paging system to advise staff of the exact location in the event of the fire alarm being activated as an additional control measure. Completed 31/01/2020

• Following additional works the paging system will be commissioned by the supplier and ready for use in February. Completion date: 29/02/2020

• The registered provider has consulted with the Oxygen supplier and new holders for Oxygen bottles have been installed in all units. The holders have been relocated as necessary. Completed date: 31/12/2019

• The registered provider has engaged with a competent external contractor to complete a professional risk assessment for Oxygen storage and to provide training on Oxygen handling and the completion of Chemical Agent Risk Assessment training to the Health & Safety coordinator on site.
Completion date: 29/02/2020

• Storage enclosures along escape corridors are not adequately enclosed in fire rated construction. This has been reviewed in conjunction with the fire safety officer in their inspection at the end on January 2020 and will be included on the agreed scope of works as per regulation 28.
Completion date: 30/09/2020

23(1)(d)
• The PIC in conjunction with the CNM2 managers will use the residents meeting as a forum to gain input from the residents where possible which will subsequently form part of the Annual Review for 2019. The information gleamed from this process will form part of the content of the Annual Review. This information will be gathered for each location within the DC by end Jan 2020 with a completion date of the Annual Review planned to be completed in March 2020.
Completion Date: 30/03/2020

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

13(1)

• A business case has been submitted to the HSE with a request to fund an increase in staffing to aid with the residents preferred community activities. The HSE have advised that they will fund an increase in staffing to develop a community integration programme to support residents on the Campus (3 posts).
Completed 31/12/2019

• The above posts will be advertised in Feb 2020 and subsequently interviews will take place with a planned start date for these three additional posts scheduled for June 2020 pending successful recruitment campaign.
Completion Date: 30/06/2020

• There are two staff members trained in Supported Self Directed Learning Model and in conjunction with the HSE Project Manager will facilitate training on this model of care to frontline staff. This is scheduled to commence in February 2020 whereby information workshops will take place within the DC.
Completion Date: 30/09/2020

13(2)(a)

• The CNM2 managers, in consultation with the Occupational Therapist, have reviewed the current implementation of Using Your Environment goals for each resident, currently assessed and identified any barriers to the achievement of goals to support residents' active participation in their home and any deficit in documentation. The CNM2 managers will also consult with the Occupational Therapist to complete the four outstanding Using Your Environment Assessments.
Completion Date: 30/03/2020

• The CNM2 managers will promote and monitor the implementation of goals on Using Your Environment to enhance residents' independence and skills teaching in each location. Completion Date: 30/06/2020

13(2)(b)

• The PIC in conjunction with the CNM2 Managers will review the existing documentation in the meaningful day section of the individual personal plans to ensure each resident has a clearly described record of preferred activities and a clear system to record when such activities have been made available to the resident. Staff members will receive mentoring in the standard required to record residents' activities and the accurate monitoring of these activities.
Completion Date: 30/06/2020

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
17(1)(a)
• The Designated Centre is closed to new admissions. Completed

• Multi occupancy rooms are no longer reallocated to another resident in the event of a vacancy.
Completed

• The registered provider is currently working jointly with the HSE in the purchase of an additional house in the community to support residents from this Designated Centre who have identified their wish to move to a community setting. CAS application is currently being progressed with a view to securing the property.
Completion date:31/08/2020

Note: (Planned move of residents will be dictated by the progress of the purchase of property, completion of adaptations to property and completion of recruitment).

17 (1)(b)
• The registered provider implements a planned schedule of maintenance on an annual basis. The service will continue to prioritise and plan maintenance in consultation with the Capital Expenditure Committee on a quarterly basis with the schedule for 2020 due to be finalised in February 2020.
Completion Date: 29/02/2020

• Following an audit on storage requirements in the relevant locations within the Designated Centre a schedule of works is currently being implemented.
Completion Date: 30/09/2020

17(7)
• The registered provider has consulted with a suitably qualified architect who has commenced the construction of an additional conservatory to two residential areas on site. These works will create an extension to two locations which will increase the living space of the residents. These conservatories will subsequently be decorated with input and consultation from the residents.
Completion Date:30/06/2020

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk

management procedures:
26(1)(a)
• The registered provider has consulted with the Oxygen supplier and new holders for Oxygen bottles have been installed in all units. The holders have been relocated as necessary. Completed Date: 31/12/2019

• The registered provider has engaged with a competent external contractor to complete a professional risk assessment for Oxygen storage and to provide training on Oxygen handling and the completion of Chemical Agent Risk Assessment training to the Health & Safety co-ordinator on site.
Completion date: 29/02/2020

26(1)(b)
• Once the above risk assessment has been completed this will be incorporated into the Risk Management Policy for each location and will include all measures and actions in place to control this risk. Completion Date: 30/06/2020

26(2)
• The registered provider has installed a paging system to advise staff of the exact location in the event of the fire alarm being activated as an additional control measure.
Completed: 31/01/2020

• Following additional works the paging system will be commissioned by the supplier and ready for use in February. Completion Date: 29/02/2020

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 28(1), 28(2)(a), 28(2)(b)(i), 28(2)(c), 28(5)
• On receipt of the Independent Fire Risk Assessments within the DC the registered provider prepared a tender document to complete all identified works.
Completed: 30/11/2019

• The registered provider completed the tender process in December
Completed: 20/12/2019

• The registered provider is engaged in negotiations with the HSE on funding for the project. The HSE as part of the process has required an additional independent Fire Safety consultant to review the scope of works and the risk assessments. The independent fire safety consultant has completed their inspection in January.
Completed: 22/01/2020

• The findings from the above mentioned inspection are due to be submitted to the registered provider by February 28th 2020. Completion date: 28/02/2020

• The registered provider will review the current scope of works based on the HSE inspection report in consultation with the architect, the HSE, the registered providers independent fire consultant in order to agree a schedule of works.
Completion Date: 30/03/2020

• The agreed scope of works will address the specific issues highlighted in the body of this report in relation to fire safety i.e. lock mechanisms on residents doors, fire stopping, recess lights, door closures, fire doors on storage areas on escape corridors.
Completion date: 30/09/2020

• The registered provider, following completion of consultation with the HSE, will implement the agreed schedule of works to reach compliance.
Completion date: 30/09/2020

28(3)(d)
• The resident identified in the report with a loose key on their bedroom door has had a break glass system installed and trialled however this was not tolerated by the resident due to their individual needs. Completed 21/11/2019

• The following additional control measures have been put in place in this location, an additional key is located on a hook beside the resident's door which is being tolerated and left in place by the resident. Completed 22/11/2019

• All staff members have a key to the resident's bedroom on their person for the duration of their shift. Completed 30/11/2019

28(3)(a)
• The registered provider has installed a paging system to advise staff of the exact location in the event of the fire alarm being activated as an additional control measure.
Completed: 31/01/2020

• Following additional works the paging system will be commissioned by the supplier and ready for use in February. Completion date: 29/02/2020

28(1), 28(4)(a)
• The registered provider has consulted with the Oxygen supplier and new holders for Oxygen bottles have been installed in all units. The holders have been relocated as necessary. Completed date: 31/12/2019

• The registered provider has engaged with a competent external contractor to complete a professional risk assessment for Oxygen storage and to provide training on Oxygen handling and the completion of Chemical Agent Risk Assessment training to the Health & Safety co-ordinator on site.
Completion date: 29/02/2020

28(3)(d), 28(4)(a), 28(4)(b)
• In the location where drill records indicated an evacuation time in excess of five minutes, the registered provider has provided significant support and external training in relation to Fire Evacuation Procedures. The most recent evacuation time for the location is two minutes and eighteen seconds.
Completed 31/10/2019

• The registered provider has commissioned an external competent fire safety personnel to deliver fire safety training to all staff and this includes demonstration and practice on the use of an evacuation sheet with a mannequin, as a standard section of the fire training. Completion date: 30/06/2020

• The registered provider is currently putting a wide tarmac path to further improve the ease of evacuation from this location for bed evacuations which will improve resident safety. Completion Date: 30/07/2020

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
9 (2)(a)
• The Person Centred Planning meeting will document rights restrictions in place and this information will be discussed with the resident and the resident's representative. This will be rolled out as planning meetings are scheduled over the annual period.
Completion date:30/09/2020

9 (2)(b)
• Where it has been noted in the body of the report that residents rights remain impacted by staff resources, and how they are allocated, the registered provider in consultation with the PIC, has reviewed the existing governance structure within the Chalets. This review assessed the current use of frontline staff and recommendations highlighted are due to be implemented in the February 2020 roster in order to ensure frontline resources are based on the current WTE and same is allocated to the maximum benefit of all residents.
Completion date: 30/03/2020

9 (2)(e)
• Where there have been inappropriate locks identified on some residents' rooms in order to protect residents property, the registered provider will consult with the Occupational Therapist to establish if an alternative locking mechanism can be used that the resident will subsequently be able to access their bedroom independently. This will then be explored on a trial basis.
Completion Date: 30/06/2020

9 (3)

• An appropriate location has been identified for the storage of residents' information and files and the PIC will liaise with the maintenance team to ensure the construction of this shelving unit is complete in order to store such information in a safe and secure location. Completion Date: 30/03/2020

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	30/09/2020
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/06/2020
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Not Compliant	Orange	30/06/2020

	accordance with their interests, capacities and developmental needs.			
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	30/06/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2020
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/08/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	30/09/2020

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2020
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	30/03/2020
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	30/09/2020
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/03/2020

Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	29/02/2020
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	30/06/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	29/02/2020
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/09/2020
Regulation	The registered	Not Compliant	Orange	30/09/2020

28(2)(a)	provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/09/2020
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	29/02/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	30/06/2020
Regulation	The registered	Substantially	Yellow	30/06/2020

28(4)(a)	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.	Compliant		
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 practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/06/2020
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Substantially Compliant	Yellow	30/09/2020
Regulation 09(2)(a)	The registered provider shall	Not Compliant	Orange	30/09/2020

	ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/03/2020
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	30/06/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and	Not Compliant	Orange	30/03/2020

	living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			